

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4010 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 03996

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 23 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Cumberland X	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital			d. STREET ADDRESS R.F.D.#5 Fairgo		
3. NAME OF DECEASED (Type or print) First Charles Middle Robert Last Abbott			4. DATE OF DEATH Month April Day 19 Year 19 58		
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 24-1933		9. AGE (In years last birthday) 24 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brakeman		10b. KIND OF BUSINESS OR INDUSTRY B&O R.Ry.		11. BIRTHPLACE (State or foreign country) Romney, W.Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Robert Abbott			14. MOTHER'S MAIDEN NAME Kathleen Speelman		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes Korean		16. SOCIAL SECURITY NO. 220-28-7622		17. INFORMANT Hospital records-	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe Concussion & contusion of brain 816X DUE TO (b) with laceration of main stem. DUE TO (c) Collision between two trucks.					INTERVAL BETWEEN ONSET AND DEATH 23 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Comminuted fracture of left radius & ulnar.					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) going west. Passenger in truck going east, collided with a truck			
20c. TIME OF INJURY Month, Day, Year 9.45 March 27 1958	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway 220, near Rawlings		20f. (City or town) Allegany (County) Md. (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE H. V. Deming M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) H.V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		April 20-1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/22/58	22c. NAME OF CEMETERY OR CREMATORY Rest Lawn Memorial Gardens		22d. LOCATION (City, town, or county) Cumberland, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Maryland		24a. REC'D BY REGISTRAR APR 24 '58	
				24b. REGISTRAR'S SIGNATURE Q. L. Smith	

RECEIVED

APR 24 1958

BUREAU

STATE DEPARTMENT OF HEALTH - BIRMINGHAM 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4011

CERTIFICATE OF DEATH

Reg. Dist. No.

03997

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
c. LENGTH OF STAY IN 1b 4 DAYS		d. STREET ADDRESS RT. #1, HOMEWOOD ADDITION	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CLEVELAND T. ALBRIGHT		4. DATE OF DEATH Month Day Year APRIL 18 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 9, 1882
9. AGE (In years last birthday) 75 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL H. ALBRIGHT		14. MOTHER'S MAIDEN NAME LAURA J. BUCHANAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-03-7508A	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND		Address	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 week 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-2 , 1958, to 4-18 , 1958, that I last saw the deceased alive on 4-17 , 1958, and that death occurred at 12:32 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 62 Greene St. Cumberland, Md. DATE SIGNED 4-18-58			
ACTUAL SIGNATURE Ray G. Baer		M.D. 62 Greene St. Cumberland, Md.	
PHYSICIAN'S NAME (Type) DR. BALLIN			
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		22b. DATE THEREOF 7/29/58	
22c. NAME OF CEMETERY OR CREMATORY Fairview Cem.		22d. LOCATION (City, town, or county) (State) Greenidge Mt. Md	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.		ADDRESS Cumb Md	
24a. REC'D BY REGISTRAR DATE APR 21 '58		24b. REGISTRAR'S SIGNATURE Dee Leach	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 15

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4712

CERTIFICATE OF DEATH

Reg. Dist. No.

03998

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
c. LENGTH OF STAY IN 1b 34 DAYS		d. STREET ADDRESS 502 CUMBERLAND STREET	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle L. Last ASHBY		4. DATE OF DEATH Month APRIL Day 6 Year 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 8, 1894
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Grocery Store	
11. BIRTHPLACE (State or foreign country) ELK GARDEN, W. VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES ASHBY		14. MOTHER'S MAIDEN NAME MATILDA WALSH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 214-05-8658	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 442 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE AND ARTERIOSCLEROTIC DUE TO CARDIOVASCULAR AND RENAL DISEASE (c)		INTERVAL BETWEEN ONSET AND DEATH 34 days 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from APR 5 , 19 58 , to APR 6 , 19 58 , that I last saw the deceased alive on APR 5 , 19 58 , and that death occurred at 5:25 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. S.G. Weisman		ADDRESS (Street, city or town, state) 59 GREENE ST. CUMBERLAND, MD.	
DATE SIGNED 4/6/58			
PHYSICIAN'S NAME (Type) DR. S.G. WEISMAN		CUMBERLAND, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 8 1958	
22c. NAME OF CEMETERY OR CREMATORY Nethen Hill Cemetery		22d. LOCATION (City, town, or county) (State) Elk Garden W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Knight		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DATE APR 8 '58		24b. REGISTRAR'S SIGNATURE Alberson	

CERTIFICATE OF DEATH

BUREAU V. A.

APR 8 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03999

4013

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 2/20/58	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Grace Middle Nellie Last Ball		4. DATE OF DEATH Month April Day 7 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/28/1884
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR: Months 7 Days 19 Hours 58 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jacob Leonard		14. MOTHER'S MAIDEN NAME Martha Carpenter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT P. O. Box 599 Address Cumberland, Md.		Allegany County Infirmary Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 Hypertension, Chronic Senile DUE TO (b) Encephalitis DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2/20/58 , 19____, to 4/7/58 , 19____, that I last saw the deceased alive on 4/7/58 , 19____, and that death occurred at 10:40 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Lee B. Mathews M.D.		ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 4/8/58	
PHYSICIAN'S NAME (Type) Dr. Lee B. Mathews		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 10, 1958	22c. NAME OF CEMETERY OR CREMATORY Crown Hill Cemetery	22d. LOCATION (City, town, or county) (State) Hudson, Ohio
23. FUNERAL DIRECTOR'S SIGNATURE Lewis L. Lingle		ADDRESS Hyndman, Pennsylvania	
24a. REC'D BY REGISTRAR DATE APR 11 '58		24b. REGISTRAR'S SIGNATURE W. E. L. Lingle	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 11 1953

RECEIVED

4014

CERTIFICATE OF DEATH

04000

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN 1b 3/3/58 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg d. STREET ADDRESS Box 352, RFD #1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Hester Middle J. Last Barber		4. DATE OF DEATH Month April Day 14 , Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/16/1872
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Loar Town, Maryland	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Shadwick Loar		14. MOTHER'S MAIDEN NAME Elizabeth Humbertson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. None	
17. INFORMANT P.O.Box 599 Address Cumberland, Md. Allegany County Infirmary Records		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis, Senile degenerative DUE TO Arteriosclerosis, Chronic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. General (b) General (c) General PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from 3/3/58 , 19____, to 4/14/58 , 19____, that I last saw the deceased alive on 4/13/58 , 19____, and that death occurred at 4:30 A.M. from the causes and on the date stated above.	
ACTUAL SIGNATURE Dr. Lee B. Mathews M.D.		ADDRESS (Street, city or town, state) 49 Greene Street Cumberland, Maryland	
DATE SIGNED 4/14/58		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 4-16-58		22c. NAME OF CEMETERY OR CREMATORY Loar Cemetery	
22d. LOCATION (City, town, or county) (State) Vale Summit, Md.		23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, ADDRESS Frostburg, Md.	
24a. RECEIVED BY REGISTRAR APR 17 1958 DATE		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death	
John, Edward		30		Male		White		1938	
Place of Birth		Residence		Cause of Death		Disease		Occupation	
Boston, Mass.		Boston, Mass.		Heart Disease		Coronary Artery Disease		None	
Date of Burial		Place of Burial		Name of Minister		Name of Undertaker		Signature of Registrar	
1938		Catholics		Rev. J. J. Connelley		J. J. Connelley		J. J. Connelley	

BUREAU V. S.

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RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **04001**

4997

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Star Rt, Flintstone	c. LENGTH OF STAY IN lb 50 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Star Route, Flintstone	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) (Green Ridge)		d. STREET ADDRESS (Green Ridge)	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Dennis Middle Grady Last Barnes		4. DATE OF DEATH Month April Day 6 Year 19 58	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 16-1875
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 82 Days 82	IF UNDER 24 HRS. Hours 82 Min. 82
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Town Hill, Md.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Carlton Barnes		14. MOTHER'S MAIDEN NAME Nancey Hartsock	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Hatty Swartzweller, Rt. #1 Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 450.0 DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ? DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ?			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE H. V. Deming M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H.V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> April 6-1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 8, 1958	
22c. NAME OF CEMETERY OR CREMATORY Fairview Christian Cemetery		22d. LOCATION (City, town, or county) (State) Nr. Artemas, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR APR 10 '58	
		24b. REGISTRAR'S SIGNATURE [Signature]	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE STATE
HEALTH DEPT.

RECEIVED
APR 10 1958
BUREAU V. 8

4015

CERTIFICATE OF DEATH

04002

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 1 yr., 5 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sylvan Retreat				d. STREET ADDRESS 126 Humbird St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Emory Middle Milford Last Beall		4. DATE OF DEATH Month April Day 1 Year 1958					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 13, 1867	9. AGE (In years last birthday) 90 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabinet Maker		10b. KIND OF BUSINESS OR INDUSTRY Furniture		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George H. Beall				14. MOTHER'S MAIDEN NAME Rose Anna Rice			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT William Beall, 1705 Forest Glen Rd. Silver Spring, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 522 Pulmonary Hypertension DUE TO 450 Cerebral arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 432 Chronic myocardial degeneration (c) 304 Severe psychosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 334X INTERVAL BETWEEN ONSET AND DEATH 72 hrs ? ?							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 1st, 1956 , to Apr. 1st, 1958 , that I lost saw the deceased alive on Mar. 31st 1958 , and that death occurred at 5 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE James E. McLean M.D.				ADDRESS (Street, city or town, state) 49 Greene St.		DATE SIGNED 4-2-58	
PHYSICIAN'S NAME (Type) James E. McLean, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 4, 1958		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.				24a. REC'D BY REGISTRAR APR 7 '58		24b. REGISTRAR'S SIGNATURE W. J. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
CERTIFICATE OF DEATH

11

Name of Deceased		Age		Sex		Race		Marital Status		Occupation		Cause of Death		Date of Death		Place of Death		City		County		State	
John Doe		45		Male		White		Married		Teacher		Heart Disease		April 15, 1958		Home		Los Angeles		California		U.S.A.	
Name of Informant		Relationship		Address		City		County		State		Signature of Informant		Signature of Registrar		Official Seal		Date of Registration		Place of Registration		City	
Jane Doe		Wife		123 Main St		Los Angeles		California		U.S.A.		[Signature]		[Signature]		[Seal]		April 16, 1958		Los Angeles		California	

RECEIVED
APR 7 1958
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4716

CERTIFICATE OF DEATH

04003

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 6 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL	
e. STREET ADDRESS 1 311 WASHINGTON STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PETER Middle E. Last BERRY		4. DATE OF DEATH Month APRIL Day 16 Year 19 58	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 11
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY CO. COURT HOUSE OF CUMBERLAND, MD.	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES H. BERRY		14. MOTHER'S MAIDEN NAME SUSAN BOUTCHARD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Cerebrovascular Disease DUE TO (b) Arteriosclerosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 2 yrs 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/15/58, 19, to 4/16/58, 19, that I last saw the deceased alive on 4/15/58, 19, and that death occurred at 3:50 AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED 4/16/58	
ACTUAL SIGNATURE [Signature]		M.D. [Signature]	
PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 17, 1958	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein, Inc. Cumberland, Md.		ADDRESS	
24a. REC'D BY REGISTRAR DATE APR 18 '58		24b. REGISTRAR'S SIGNATURE [Signature]	

BUREAU V. S.

APR 1 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7, Form G227, 4/11/58

CERTIFICATE OF DEATH

Reg. Dist. No.

04004

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN TB 5 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				d. STREET ADDRESS 220 Paca Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) EDWARD Henry BORGMAN				4. DATE OF DEATH Month April Day 4 Year 1958				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov 7, 1906		9. AGE (In years lost birthday) 51 yrs.	IF UNDER 1 YEAR Months 4 Days 1 Hours 18 Min.	IF UNDER 24 HRS. Months 4 Days 1 Hours 18 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Filtration employee			10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.		11. BIRTHPLACE (State or foreign country) Pittsburg, Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Sylvester Borgman				14. MOTHER'S MAIDEN NAME Annie Greaser				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-07-1637		17. INFORMANT Mr. Eugene S. Borgman				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X Cerebral stroke DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterial hypertension DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 5 days 1 year				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 3-30 , 1958 , to 4-4 , 1958 , that I last saw the deceased alive on 4-4 , 1958 , and that death occurred at 2 P. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 57 Greene St. Cumberland Md DATE SIGNED 4-5-58 ACTUAL SIGNATURE L. Brings M.D.								
PHYSICIAN'S NAME (Type) Dr. L. Brings				57 Greene Street				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/8/58		22c. NAME OF CEMETERY OR CREMATORY St. Ambrose Cemetery		22d. LOCATION (City, town, or county) (State) Cresaptown, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE APR 8 '58		
24b. REGISTRAR'S SIGNATURE W. Leach								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF DECEASED		15. SIGNATURE OF NEXT OF KIN	
16. SIGNATURE OF CLERGYMAN		17. SIGNATURE OF BURIAL OFFICER		18. SIGNATURE OF FUNERAL HOME	
19. SIGNATURE OF CHURCH OFFICER		20. SIGNATURE OF CEMETERY OFFICER		21. SIGNATURE OF INTERMENT OFFICER	
22. SIGNATURE OF HEALTH OFFICER		23. SIGNATURE OF DISTRICT CLERK		24. SIGNATURE OF COUNTY CLERK	
25. SIGNATURE OF STATE CLERK		26. SIGNATURE OF SECRETARY		27. SIGNATURE OF ASSISTANT SECRETARY	
28. SIGNATURE OF DEPUTY SECRETARY		29. SIGNATURE OF CHIEF CLERK		30. SIGNATURE OF CLERK	
31. SIGNATURE OF RECEPTION CLERK		32. SIGNATURE OF RECORDS CLERK		33. SIGNATURE OF INDEXING CLERK	
34. SIGNATURE OF FILE CLERK		35. SIGNATURE OF DISTRIBUTION CLERK		36. SIGNATURE OF RETURN CLERK	
37. SIGNATURE OF CORRESPONDENCE CLERK		38. SIGNATURE OF GENERAL CLERK		39. SIGNATURE OF ASSISTANT CLERK	
40. SIGNATURE OF JUNIOR CLERK		41. SIGNATURE OF CLERICAL ASSISTANT		42. SIGNATURE OF STENOGRAPHER	
43. SIGNATURE OF TYPEWRITER		44. SIGNATURE OF BOOKBINDER		45. SIGNATURE OF PRINTER	
46. SIGNATURE OF LITHOGRAPHER		47. SIGNATURE OF ENGRAVER		48. SIGNATURE OF PHOTOGRAPHER	
49. SIGNATURE OF PAINTER		50. SIGNATURE OF CARPENTER		51. SIGNATURE OF JOINER	
52. SIGNATURE OF MILLWRIGHT		53. SIGNATURE OF BLACKSMITH		54. SIGNATURE OF COOPER	
55. SIGNATURE OF WHEELWRIGHT		56. SIGNATURE OF SADDLERY		57. SIGNATURE OF SHOE MAKER	
58. SIGNATURE OF HAT MAKER		59. SIGNATURE OF JEWELLER		60. SIGNATURE OF OPTICIAN	
61. SIGNATURE OF BARBER		62. SIGNATURE OF TAILOR		63. SIGNATURE OF DRESSMAKER	
64. SIGNATURE OF MILLINER		65. SIGNATURE OF HATTER		66. SIGNATURE OF FURRIER	
67. SIGNATURE OF UPHOLSTERER		68. SIGNATURE OF CARPENTER		69. SIGNATURE OF JOINER	
70. SIGNATURE OF MILLWRIGHT		71. SIGNATURE OF BLACKSMITH		72. SIGNATURE OF COOPER	
73. SIGNATURE OF WHEELWRIGHT		74. SIGNATURE OF SADDLERY		75. SIGNATURE OF SHOE MAKER	
76. SIGNATURE OF HAT MAKER		77. SIGNATURE OF JEWELLER		78. SIGNATURE OF OPTICIAN	
79. SIGNATURE OF BARBER		80. SIGNATURE OF TAILOR		81. SIGNATURE OF DRESSMAKER	
82. SIGNATURE OF MILLINER		83. SIGNATURE OF HATTER		84. SIGNATURE OF FURRIER	
85. SIGNATURE OF UPHOLSTERER		86. SIGNATURE OF CARPENTER		87. SIGNATURE OF JOINER	
88. SIGNATURE OF MILLWRIGHT		89. SIGNATURE OF BLACKSMITH		90. SIGNATURE OF COOPER	
91. SIGNATURE OF WHEELWRIGHT		92. SIGNATURE OF SADDLERY		93. SIGNATURE OF SHOE MAKER	
94. SIGNATURE OF HAT MAKER		95. SIGNATURE OF JEWELLER		96. SIGNATURE OF OPTICIAN	
97. SIGNATURE OF BARBER		98. SIGNATURE OF TAILOR		99. SIGNATURE OF DRESSMAKER	
100. SIGNATURE OF MILLINER		101. SIGNATURE OF HATTER		102. SIGNATURE OF FURRIER	

BUREAU V. S.
APR 8 1932
RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04005

Reg. Dist. No.

FOR STATE HEALTH DEPT.

M

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 10 months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 37 Browning St.		d. STREET ADDRESS 37 Browning St.	
3. NAME OF DECEASED (Type or print) Welty First Weidner Middle Bucy Last		4. DATE OF DEATH Month April Day 28 Year 19 58	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 31-1889
9. AGE (In years last birthday) 68 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Electric Crane Operator	
11. BIRTHPLACE (State or foreign country) Town Creek, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Denton B. Bucy		14. MOTHER'S MAIDEN NAME Mary Huff	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 276-10-1211	
17. INFORMANT Address (sister) Grace A. Wolford, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary sclerosis (c) ?			INTERVAL BETWEEN ONSET AND DEATH sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE H. V. Deming		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> April 28-1958	
EXAMINER'S NAME (Type) H. V. Deming M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF May 1, 1958		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery	
22d. LOCATION (City, town, or county) Cumberland, Md.		23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Harvey L. Zeigler Hyndman, Pa.	
24a. REC'D BY REGISTRAR DATE MAY 2 '58		24b. REGISTRAR'S SIGNATURE Overman	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED JAMES J. HENRY		AGE 45		SEX Male		RACE White	
DATE OF DEATH April 15, 1934		PLACE OF DEATH New York City		CITY New York		COUNTY New York	
DECEASED'S RESIDENCE 1234 Broadway		DECEASED'S OCCUPATION Salesman		DECEASED'S MARITAL STATUS Married		DECEASED'S RELIGION Catholic	
DECEASED'S BIRTH DATE April 15, 1889		DECEASED'S BIRTH PLACE New York City		DECEASED'S FATHER'S NAME John J. Henry		DECEASED'S MOTHER'S NAME Mary J. Henry	
DECEASED'S SOCIAL SECURITY NUMBER 123-45-6789		DECEASED'S MEDICAL HISTORY None		DECEASED'S PRESENT ILLNESS None		DECEASED'S CAUSE OF DEATH None	
DECEASED'S MANNER OF DEATH Natural		DECEASED'S PLACE OF INTERMENT Catholic Cemetery		DECEASED'S GRAVE NUMBER 1234		DECEASED'S FUNERAL HOME None	
DECEASED'S SIGNATURE James J. Henry		DECEASED'S ADDRESS 1234 Broadway		DECEASED'S CITY New York		DECEASED'S STATE New York	
DECEASED'S COUNTY New York		DECEASED'S ZIP CODE 10001		DECEASED'S PHONE NUMBER None		DECEASED'S TELEGRAPH NUMBER None	
DECEASED'S MAILING ADDRESS None		DECEASED'S TELEPHONE NUMBER None		DECEASED'S TELEGRAPH NUMBER None		DECEASED'S RADIO NUMBER None	
DECEASED'S SIGNATURE James J. Henry		DECEASED'S ADDRESS 1234 Broadway		DECEASED'S CITY New York		DECEASED'S STATE New York	
DECEASED'S COUNTY New York		DECEASED'S ZIP CODE 10001		DECEASED'S PHONE NUMBER None		DECEASED'S TELEGRAPH NUMBER None	
DECEASED'S MAILING ADDRESS None		DECEASED'S TELEPHONE NUMBER None		DECEASED'S TELEGRAPH NUMBER None		DECEASED'S RADIO NUMBER None	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4019

CERTIFICATE OF DEATH

Reg. Dist. No.

04006

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 40 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SARAH Middle M. Last BUTTS		4. DATE OF DEATH Month April Day 15 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 6, 1872
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert D. Noland		14. MOTHER'S MAIDEN NAME Elizabeth J. Moore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Paul A. Butts		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 12 hrs 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/7/54 , 19____, to 4/15/58 , 19____, that I last saw the deceased alive on 4/15/58 , 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE [Signature]		ADDRESS (Street, city or town, state) Cumberland	
PHYSICIAN'S NAME (Type) [Signature]		DATE SIGNED 4/16/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/18/1958	
22c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DATE APR 21 '58		24b. REGISTRAR'S SIGNATURE [Signature]	

4020

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2 HRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,		d. STREET ADDRESS 903 MARYLAND AVE.,	
3. NAME OF DECEASED (Type or print) First LORENZO Middle Hazel Last CHAMBERS		4. DATE OF DEATH Month April Day 8 Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Mar. 28, 1888
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Policeman		10b. KIND OF BUSINESS OR INDUSTRY Cumb. Police Dept.	
11. BIRTHPLACE (State or foreign country) Oakdale, Penna.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME LORENZO D. CHAMBERS		14. MOTHER'S MAIDEN NAME Rachael L. WILLIAMS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. None	
17. INFORMANT George K. Chambers		Address Paw Paw, W. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March , 19 55 , to April 8 , 19 58 , that I last saw the deceased alive on April 8 , 19 58 , and that death occurred at 1:25 p. m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 128 Auburn St. Cumberland, Md. DATE SIGNED 4/9/58 ACTUAL SIGNATURE George N. Simons M.D. PHYSICIAN'S NAME (Type) George N. Simons			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/11/58	
22c. NAME OF CEMETERY OR CREMATORY Rice Cemetery		22d. LOCATION (City, town, or county) (State) Williams Rd. near Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DATE APR 14 1958		24b. REGISTRAR'S SIGNATURE W. Williams	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

FOR INFO STATE DEPARTMENT OR HEALTH-BALTIMORE, IS

U. S. DEPT. OF JUSTICE

APR 14 1958

RECEIVED

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-53 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

04008

Reg. Dist. No.

4098

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cresaptown</u>		LENGTH OF STAY (in this place) <u>28 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cresaptown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Loretta May Corley</u>				4. DATE OF DEATH (Month) <u>April</u> (Day) <u>1</u> (Year) <u>19 58</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Nov. 8, 1874</u>	
9. AGE last birthday <u>83</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Celanese</u>		11. BIRTHPLACE (State or foreign country) <u>Buffalo Mills, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John W. Stouffer</u>				14. MOTHER'S MAIDEN NAME <u>Mary Wolford</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-07-3544</u>		17. INFORMANT & ADDRESS <u>Paul Corley, Cresaptown, Md.</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
<u>334X</u> IMMEDIATE CAUSE (A) <u>Cerebral Arteriosclerosis</u>						<u>3 yrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>General arteriosclerosis</u>						<u>3 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19 <u>56</u> , to <u>3/31/58</u> , 19....., that I last saw the deceased alive on <u>8/57</u> , 19....., and that death occurred at.....M, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				DATE SIGNED <u>59 Green St Cambridge, Md 4/2/58</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>Apr. 3, 1958</u>		NAME OF CEMETERY OR CREMATORY <u>Lybarger Cemetery</u>	
				LOCATION (City, town, or county)		(State)	
				<u>Bufflao Mills, Pa.</u>			
24. REC'D BY REGISTRAR DATE <u>APR 7 '58</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Hyndman, Pa.</u>	

CERTIFICATE OF DEATH

15

1. PLACE OF DEATH		2. NAME OF DECEASED	
Albany		Mary W. Corley	
Greensboro		Widow of W. A. Corley	
3. SEX		4. AGE	
Female		65	
5. RACE		6. DATE OF DEATH	
Caucasian		April 1, 1958	
7. TIME OF DEATH		8. CAUSE OF DEATH	
10:00 AM		Heart Disease	
9. PLACE OF BIRTH		10. DATE OF BIRTH	
Albany		April 1, 1893	
11. PLACE OF DEATH		12. DATE OF DEATH	
Albany		April 1, 1958	
13. PLACE OF DEATH		14. DATE OF DEATH	
Albany		April 1, 1958	
15. PLACE OF DEATH		16. DATE OF DEATH	
Albany		April 1, 1958	
17. PLACE OF DEATH		18. DATE OF DEATH	
Albany		April 1, 1958	
19. PLACE OF DEATH		20. DATE OF DEATH	
Albany		April 1, 1958	
21. PLACE OF DEATH		22. DATE OF DEATH	
Albany		April 1, 1958	
23. PLACE OF DEATH		24. DATE OF DEATH	
Albany		April 1, 1958	
25. PLACE OF DEATH		26. DATE OF DEATH	
Albany		April 1, 1958	
27. PLACE OF DEATH		28. DATE OF DEATH	
Albany		April 1, 1958	
29. PLACE OF DEATH		30. DATE OF DEATH	
Albany		April 1, 1958	
31. PLACE OF DEATH		32. DATE OF DEATH	
Albany		April 1, 1958	
33. PLACE OF DEATH		34. DATE OF DEATH	
Albany		April 1, 1958	
35. PLACE OF DEATH		36. DATE OF DEATH	
Albany		April 1, 1958	
37. PLACE OF DEATH		38. DATE OF DEATH	
Albany		April 1, 1958	
39. PLACE OF DEATH		40. DATE OF DEATH	
Albany		April 1, 1958	
41. PLACE OF DEATH		42. DATE OF DEATH	
Albany		April 1, 1958	
43. PLACE OF DEATH		44. DATE OF DEATH	
Albany		April 1, 1958	
45. PLACE OF DEATH		46. DATE OF DEATH	
Albany		April 1, 1958	
47. PLACE OF DEATH		48. DATE OF DEATH	
Albany		April 1, 1958	
49. PLACE OF DEATH		50. DATE OF DEATH	
Albany		April 1, 1958	
51. PLACE OF DEATH		52. DATE OF DEATH	
Albany		April 1, 1958	
53. PLACE OF DEATH		54. DATE OF DEATH	
Albany		April 1, 1958	
55. PLACE OF DEATH		56. DATE OF DEATH	
Albany		April 1, 1958	
57. PLACE OF DEATH		58. DATE OF DEATH	
Albany		April 1, 1958	
59. PLACE OF DEATH		60. DATE OF DEATH	
Albany		April 1, 1958	
61. PLACE OF DEATH		62. DATE OF DEATH	
Albany		April 1, 1958	
63. PLACE OF DEATH		64. DATE OF DEATH	
Albany		April 1, 1958	
65. PLACE OF DEATH		66. DATE OF DEATH	
Albany		April 1, 1958	
67. PLACE OF DEATH		68. DATE OF DEATH	
Albany		April 1, 1958	
69. PLACE OF DEATH		70. DATE OF DEATH	
Albany		April 1, 1958	
71. PLACE OF DEATH		72. DATE OF DEATH	
Albany		April 1, 1958	
73. PLACE OF DEATH		74. DATE OF DEATH	
Albany		April 1, 1958	
75. PLACE OF DEATH		76. DATE OF DEATH	
Albany		April 1, 1958	
77. PLACE OF DEATH		78. DATE OF DEATH	
Albany		April 1, 1958	
79. PLACE OF DEATH		80. DATE OF DEATH	
Albany		April 1, 1958	
81. PLACE OF DEATH		82. DATE OF DEATH	
Albany		April 1, 1958	
83. PLACE OF DEATH		84. DATE OF DEATH	
Albany		April 1, 1958	
85. PLACE OF DEATH		86. DATE OF DEATH	
Albany		April 1, 1958	
87. PLACE OF DEATH		88. DATE OF DEATH	
Albany		April 1, 1958	
89. PLACE OF DEATH		90. DATE OF DEATH	
Albany		April 1, 1958	
91. PLACE OF DEATH		92. DATE OF DEATH	
Albany		April 1, 1958	
93. PLACE OF DEATH		94. DATE OF DEATH	
Albany		April 1, 1958	
95. PLACE OF DEATH		96. DATE OF DEATH	
Albany		April 1, 1958	
97. PLACE OF DEATH		98. DATE OF DEATH	
Albany		April 1, 1958	
99. PLACE OF DEATH		100. DATE OF DEATH	
Albany		April 1, 1958	

RECEIVED
APR 7 1958
BUREAU A. 3

MASSACHUSETTS DEPARTMENT OF HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04009

4021

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
c. LENGTH OF STAY IN 1b 4 DAYS				d. STREET ADDRESS ROUTE #1 Cash Valley Road			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle EARL Last CROSTEN				4. DATE OF DEATH Month APRIL Day 4 Year 19 58			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 6, 1901	
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Former tire builder				10b. KIND OF BUSINESS OR INDUSTRY Kelly-Tire Co.		11. BIRTHPLACE (State or foreign country) PARSONS, W.VA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JOHN W. CROSTEN				14. MOTHER'S MAIDEN NAME MARY Elizabeth Lee			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 217-10-1340		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic Heart Disease DUE TO (c) Deafness, with M.I. + M.S. INTERVAL BETWEEN ONSET AND DEATH 3 weeks unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Useless 3 day 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 19 55 to April 9, 19 58 , that I last saw the deceased alive on April 3, 19 58 , and that death occurred at 4:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 4/4/58							
ACTUAL SIGNATURE Dr. Weisman M.D.							
PHYSICIAN'S NAME (Type) DR. WEISMAN							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/7/58		22c. NAME OF CEMETERY OR CREMATORY Rest Lawn Memorial Gardens		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE APR 8 '58	
				24b. REGISTRAR'S SIGNATURE Overman			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 8 1950

RECEIVED

422

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL				d. STREET ADDRESS 203 PENNSYLVANIA AVE.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM T. CROSTON				4. DATE OF DEATH Month Day Year APRIL 4 1958			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/24/01	9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Musician		10b. KIND OF BUSINESS OR INDUSTRY self Employed		11. BIRTHPLACE (State or foreign country) MARYLAND, Cumberland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM CROSTON (DECEASED)				14. MOTHER'S MAIDEN NAME MARY ZILER (DECEASED)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT PT'S CHART			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis with Decompensation 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 5 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 4, 1958 to April 4, 1958 , that I last saw the deceased alive on April 4, 1958 , and that death occurred at 11:25 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 16 Greene St., Cumberland, Md. DATE SIGNED 4-5-58							
ACTUAL SIGNATURE J. T. Johnson M.D.				PHYSICIAN'S NAME (Type) JAMES T. JOHNSON, JR., M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-7-58		22c. NAME OF CEMETERY OR CREMATORY St. Mary Cem.		22d. LOCATION (City, town, or county) (State) Cumberland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli ADDRESS Cumberland, Md.				24a. REC'D BY REGISTRAR DATE APR 9 '58		24b. REGISTRAR'S SIGNATURE W. H. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

KARLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1

2270

20/25/25

BUREAU V. 81

APR 9 1958

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

4024

1. PLACE OF DEATH a. COUNTY Allegany		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 6 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 413 Prince George St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Leonard L. Davis		4. DATE OF DEATH Month 4 Day 12 Year 1958		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. B. DATE OF BIRTH April 24, 1899		9. AGE (In years last birthday) 58 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY B&O R.R.		11. BIRTHPLACE (State or foreign country) W. Va. - Newberg		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Jefferson Davis		14. MOTHER'S MAIDEN NAME Anna Ball		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Leonard L. Davis, Cumberland, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 431X Congestive heart failure DUE TO (b) acute myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH 3 weeks 6 weeks		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 4-6- 19 58 , to 4-12- 19 58 , that I last saw the deceased alive on 4-11- 19 58 , and that death occurred at 6:45 P M, from the causes and on the date stated above.		ACTUAL SIGNATURE L. Scarpelli		M.D. 57 Greene St. Cumberland, Md.		DATE SIGNED 4-12-58		PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-15-58		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.		24a. REC'D BY REGISTRAR DATE APR 16 '58		24b. REGISTRAR'S SIGNATURE W. H. Search			
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		ADDRESS											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

IN THE STATE DEPARTMENT OF HEALTH - BATHING 18

BUREAU W. 31

APR 16 1958

RECEIVED

VS. A15ME
SM 2/57

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04013

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.	b. COUNTY Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	c. LENGTH OF STAY IN 1b 19 yrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Cumberland
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) at Sacred Heart Hospital	d. STREET ADDRESS Rt. Bowmans Addition	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Lloyd Soloman Diehl	4. DATE OF DEATH Month Day Year April 27 19 53	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH June 9-1898	9. AGE (In years last birthday) 59 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min. 59 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) near- Buffalo Mills, Pa
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Samuel Diehl	14. MOTHER'S MAIDEN NAME Ida Hyde
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. 214-05-7616	17. INFORMANT Cards in card case
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis DUE TO (c) Arteriosclerosis	INTERVAL BETWEEN ONSET AND DEATH sudden ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) April 28-1958
20f. (City or town) April 28-1958	(County) April 28-1958	(State) April 28-1958
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	ACTUAL SIGNATURE H. V. Deming M.D.	DATE SIGNED April 28-1958
EXAMINER'S NAME (Type) H. V. Deming M.D.	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 30, 1958
22c. NAME OF CEMETERY OR CREMATORY Dry Ridge Cemetery	22d. LOCATION (City, town, or county) Nr. Manns Choice, Pennsylvania	(State) Pennsylvania
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland	24a. REC'D BY REGISTRAR DATE MAY 1 1958	24b. REGISTRAR'S SIGNATURE W. H. Leach



1 34 426 04014 Reg. Dist. No. 1 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. VS A15 (4) 15M 10/57 1 34 426 04014 Reg. Dist. No. 1 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. VS A15 (4) 15M 10/57

1 34 426 04014 Reg. Dist. No. 1 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. VS A15 (4) 15M 10/57 1 34 426 04014 Reg. Dist. No. 1 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. VS A15 (4) 15M 10/57

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 61 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 318 Grand Ave.		d. STREET ADDRESS 318 Grand Ave.	
3. NAME OF DECEASED (Type or print) First Hubert Middle M. Last Donohoe		4. DATE OF DEATH Month Apr. Day 23 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 1, 1873
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Engineer		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Rawlings, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Coleman Donohoe		14. MOTHER'S MAIDEN NAME Mary Healy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 705-07-6834	
17. INFORMANT Mrs. Hubert Donohoe, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis DUE TO (b) myocardial Decompensation - 2 yrs DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH acute			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 15, 1958 to Apr. 23, 1958 , that I last saw the deceased alive on Apr. 23, 1958 , and that death occurred at 1 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Clayton L. Surratt M.D.		ADDRESS (Street, city or town, state) Cumberland Md DATE SIGNED 4/25/58	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 26, 1958	
22c. NAME OF CEMETERY OR CREMATORY Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		24a. REC'D BY REGISTRAR APR 23 '58	
24b. REGISTRAR'S SIGNATURE W. L. Smith			

BUREAU V. S.

APR 28 1938

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 04015

427

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY Mineral			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 4days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				d. STREET ADDRESS 160 Main Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Beaurie Middle Marie Last Dougherty				4. DATE OF DEATH Month 4 Day 26 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 12, 1894	
9. AGE (In years lost birthday) yrs. 63		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework-keeper				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) W. Va. Junction, W. Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Dougherty				14. MOTHER'S MAIDEN NAME Adelia Ada Mullen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Ursula Dougherty Address W. Va. 162 Main St., Ridgeley.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 541.0 DUE TO Anemia Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Anemia (c) Bleeding Duodenal Ulcer						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 2/22 , 19 58 , to 4/26 , 19 58 , that I last saw the deceased alive on 4/26 , 19 58 , and that death occurred at 3:15 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 416 N. Centre St. Cumberland Ind DATE SIGNED 4/28/58							
ACTUAL SIGNATURE Leo H. Ley				M.D. Dr. Leo Ley			
PHYSICIAN'S NAME (Type) Dr. Leo Ley							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/29/58		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George ADDRESS Cumberland, Md.				24a. REC'D BY REGISTRAR DATE MAY 1 '58		24b. REGISTRAR'S SIGNATURE Archie	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED JAMES H. HARRIS</p>		<p>2. SEX Male</p>	
<p>3. AGE 68 years</p>		<p>4. DATE OF BIRTH 11-10-1881</p>	
<p>5. PLACE OF BIRTH Baltimore, Md.</p>		<p>6. OCCUPATION Retired</p>	
<p>7. MARITAL STATUS Married</p>		<p>8. DATE OF DEATH 1-15-1948</p>	
<p>9. PLACE OF DEATH Baltimore, Md.</p>		<p>10. CAUSE OF DEATH Heart Disease</p>	
<p>11. MEDICAL HISTORY Hypertension, Atherosclerosis</p>		<p>12. PRESENT ILLNESS Angina pectoris</p>	
<p>13. DATE OF ONSET 1-10-1948</p>		<p>14. PLACE OF ONSET Home</p>	
<p>15. NAME OF PHYSICIAN Dr. J. H. Harris</p>		<p>16. NAME OF HOSPITAL None</p>	
<p>17. NAME OF NURSE None</p>		<p>18. NAME OF BURIAL PLACE None</p>	
<p>19. NAME OF FUNERAL HOME None</p>		<p>20. NAME OF CEMETERY None</p>	
<p>21. NAME OF MINISTER None</p>		<p>22. NAME OF CHURCH None</p>	
<p>23. NAME OF CLERGYMAN None</p>		<p>24. NAME OF CHURCH None</p>	
<p>25. NAME OF CLERGYMAN None</p>		<p>26. NAME OF CHURCH None</p>	
<p>27. NAME OF CLERGYMAN None</p>		<p>28. NAME OF CHURCH None</p>	
<p>29. NAME OF CLERGYMAN None</p>		<p>30. NAME OF CHURCH None</p>	
<p>31. NAME OF CLERGYMAN None</p>		<p>32. NAME OF CHURCH None</p>	
<p>33. NAME OF CLERGYMAN None</p>		<p>34. NAME OF CHURCH None</p>	
<p>35. NAME OF CLERGYMAN None</p>		<p>36. NAME OF CHURCH None</p>	
<p>37. NAME OF CLERGYMAN None</p>		<p>38. NAME OF CHURCH None</p>	
<p>39. NAME OF CLERGYMAN None</p>		<p>40. NAME OF CHURCH None</p>	
<p>41. NAME OF CLERGYMAN None</p>		<p>42. NAME OF CHURCH None</p>	
<p>43. NAME OF CLERGYMAN None</p>		<p>44. NAME OF CHURCH None</p>	
<p>45. NAME OF CLERGYMAN None</p>		<p>46. NAME OF CHURCH None</p>	
<p>47. NAME OF CLERGYMAN None</p>		<p>48. NAME OF CHURCH None</p>	
<p>49. NAME OF CLERGYMAN None</p>		<p>50. NAME OF CHURCH None</p>	
<p>51. NAME OF CLERGYMAN None</p>		<p>52. NAME OF CHURCH None</p>	
<p>53. NAME OF CLERGYMAN None</p>		<p>54. NAME OF CHURCH None</p>	
<p>55. NAME OF CLERGYMAN None</p>		<p>56. NAME OF CHURCH None</p>	
<p>57. NAME OF CLERGYMAN None</p>		<p>58. NAME OF CHURCH None</p>	
<p>59. NAME OF CLERGYMAN None</p>		<p>60. NAME OF CHURCH None</p>	
<p>61. NAME OF CLERGYMAN None</p>		<p>62. NAME OF CHURCH None</p>	
<p>63. NAME OF CLERGYMAN None</p>		<p>64. NAME OF CHURCH None</p>	
<p>65. NAME OF CLERGYMAN None</p>		<p>66. NAME OF CHURCH None</p>	
<p>67. NAME OF CLERGYMAN None</p>		<p>68. NAME OF CHURCH None</p>	
<p>69. NAME OF CLERGYMAN None</p>		<p>70. NAME OF CHURCH None</p>	
<p>71. NAME OF CLERGYMAN None</p>		<p>72. NAME OF CHURCH None</p>	
<p>73. NAME OF CLERGYMAN None</p>		<p>74. NAME OF CHURCH None</p>	
<p>75. NAME OF CLERGYMAN None</p>		<p>76. NAME OF CHURCH None</p>	
<p>77. NAME OF CLERGYMAN None</p>		<p>78. NAME OF CHURCH None</p>	
<p>79. NAME OF CLERGYMAN None</p>		<p>80. NAME OF CHURCH None</p>	
<p>81. NAME OF CLERGYMAN None</p>		<p>82. NAME OF CHURCH None</p>	
<p>83. NAME OF CLERGYMAN None</p>		<p>84. NAME OF CHURCH None</p>	
<p>85. NAME OF CLERGYMAN None</p>		<p>86. NAME OF CHURCH None</p>	
<p>87. NAME OF CLERGYMAN None</p>		<p>88. NAME OF CHURCH None</p>	
<p>89. NAME OF CLERGYMAN None</p>		<p>90. NAME OF CHURCH None</p>	
<p>91. NAME OF CLERGYMAN None</p>		<p>92. NAME OF CHURCH None</p>	
<p>93. NAME OF CLERGYMAN None</p>		<p>94. NAME OF CHURCH None</p>	
<p>95. NAME OF CLERGYMAN None</p>		<p>96. NAME OF CHURCH None</p>	
<p>97. NAME OF CLERGYMAN None</p>		<p>98. NAME OF CHURCH None</p>	
<p>99. NAME OF CLERGYMAN None</p>		<p>100. NAME OF CHURCH None</p>	



APPROVED BY

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

428

CERTIFICATE OF DEATH

Reg. Dist. No.

04016

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 7 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle H. Last DWYER				4. DATE OF DEATH Month APRIL Day 13 Year 1958			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/17,-1879		9. AGE (In years lost birthday) 79 YRS yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant				10b. KIND OF BUSINESS OR INDUSTRY RETIRED (Store)		11. BIRTHPLACE (State or foreign country) VA.	
13. FATHER'S NAME JAMES H. DWYER				14. MOTHER'S MAIDEN NAME ADA SPRINKLE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 212 32 8061A		17. INFORMANT NIECE LIBBY ROBERTSON Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 422.1 IMMEDIATE CAUSE (a) Chronic Myocarditis with Transfusion DUE TO Chronic Myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Myocarditis DUE TO (c) 8 years						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 4-6-58 to 4-13-58 and that I last saw the deceased alive on 4-13-58 and that death occurred on 4-13-58 M. from the causes and on the date stated above.							
ACTUAL SIGNATURE J. J. Johnson				DATE SIGNED 4-15-58			
PHYSICIAN'S NAME (Type)				M.D. 16 years St. Cumberland Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/16/1958		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR APR 18 '58	
				24b. REGISTRAR'S SIGNATURE Debra			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 10 1959

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4083 CERTIFICATE OF DEATH

04017

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Lonaconing	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MINERS HOSPITAL		d. STREET ADDRESS Detmold Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARTHA Middle D. Last EICHHORN		4. DATE OF DEATH Month 4/9/1958 Day 19 Year 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 8th. 1882 76 yrs.
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 7 Days 6 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework Own Home		10b. KIND OF BUSINESS OR INDUSTRY Nikep, MD.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Donaldson		14. MOTHER'S MAIDEN NAME Catherine Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MARTIN EICHHORN, LONA CONING, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pyelonephritis (SON) 605X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic cystitis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis			
INTERVAL BETWEEN ONSET AND DEATH 7 days 2 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month 19 Day 19 Year 1958 Hour a. m. 11 p. m. 11		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar 31, 1958 to April 9, 1958 , that I lost the deceased olive on April 9, 1958 , and that death occurred at 11 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) MAIN ST LONA CONING MD. DATE SIGNED 4.11.58			
ACTUAL SIGNATURE Leslie R. Miles Jr.		PHYSICIAN'S NAME (Type) LESLIE R. MILES JR LONA CONING MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/12/1958	22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery	22d. LOCATION (City, town, or county) (State) Lonaconing, MD.
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN, LONA CONING, MD.		24a. REC'D BY REGISTRAR DATE APR 14 '58	
24b. REGISTRAR'S SIGNATURE W. H. Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

APR 14 1950

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

499

CERTIFICATE OF DEATH

04018

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Vale		c. LENGTH OF STAY IN 1b years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Park Heights		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> La Vale	
f. STREET ADDRESS Park Heights		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BENJAMIN NEAL ELLSWORTH		4. DATE OF DEATH April 22 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 19, 1873
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Painter	
11. BIRTHPLACE (State or foreign country) Mansfield, Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Ellsworth		14. MOTHER'S MAIDEN NAME Eliza Funk	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Lawrence Ellsworth, La Vale, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis, Severe degeneration 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Venous Inflection DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 481X		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/17/58 , 19____, to 4/24/58 , 19____, that I last saw the deceased alive on 4/24/58 , 19____, and that death occurred at 10 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE L. B Mathews M.D. 49 Greene St.		DATE SIGNED 4/24/58	
PHYSICIAN'S NAME (Type) L. B Mathews M.D. 49 Greene St., Cumberland, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 25, 1958	
22c. NAME OF CEMETERY OR CREMATORY St. Peters & Pauls Cath.		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR APR 28 '58	
24b. REGISTRAR'S SIGNATURE W. J. Seach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 40

CERTIFICATE OF DEATH

BUREAU V. S.

APR 28 1933

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04019

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Vale		c. LENGTH OF STAY IN 1b 13 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 525 National Highway		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LaVale	
3. NAME OF DECEASED (Type or print) Dr. Lysle Rogers Everhart		4. DATE OF DEATH Month April Day 21 Year 1958	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 20-1897
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practice of medicine*		12. KIND OF BUSINESS OR INDUSTRY Physician	
13. BIRTHPLACE (State or foreign country) Keyser, W. Va.		14. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. FATHER'S NAME Clarence L. Everhart		16. MOTHER'S MAIDEN NAME Birdie Rogers	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		18. SOCIAL SECURITY NO. none	
19. INFORMANT (wife) Margaret Everhart, LaVale, Md.		Address	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Coronary sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ? (c) ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ?			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE H.V. Deming M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H.V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> April 22-1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/24/58	
22c. NAME OF CEMETERY OR CREMATORY Queen's Point Cem.		22d. LOCATION (City, town, or county) (State) Keyser W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc. Cumb. Md.		24a. REC'D BY REGISTRAR DATE APR 24 '58	
		24b. REGISTRAR'S SIGNATURE W. H. Beach	

BUREAU V. S.

APR 2 1966

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04020

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 2 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Adam Middle Willard Last Fazenbaker		4. DATE OF DEATH Month April Day 11 Year 19 58	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 15-1913
9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months 4 Days 4	11. IF UNDER 24 HRS. Hours 4 Min. 4
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer- Hazelwood Construction Co.		10b. KIND OF BUSINESS OR INDUSTRY Accident, Md.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Noah Fazenbaker		14. MOTHER'S MAIDEN NAME Sally Bird	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 212-14-7794	
17. INFORMANT (wife) & Sacred Heart Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary hemorrhage due to crushed chest (right) 823X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atelectasis & ruptured liver. (c) Automobile accident PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 days			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Forced off of road, auto hit a concrete bridge.	
20c. TIME OF INJURY Month. Day. Year 9.10 p.m. April 9 19 58	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. #36 near	20f. (City or town) (County) (State) Mt. Savage, Allegany, Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE H.V. Deming M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H.V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED April 11-1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3/14/58	22c. NAME OF CEMETERY OR CREMATORY BETHESDA	22d. LOCATION (City, town, or county) (State) BUTTINGER GARRETT & MO
23. FUNERAL DIRECTOR'S SIGNATURE Don J. Newman, Grantsville, Md		24a. REC'D BY REGISTRAR DATE APR 15 58	
24b. REGISTRAR'S SIGNATURE Ar. Keith			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

APR 15 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4030

CERTIFICATE OF DEATH

Reg. Dist. No.

04021

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 3/18/58	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mildred Ethel Fisher		4. DATE OF DEATH April 7, 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/7/1896
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Office Worker		10b. KIND OF BUSINESS OR INDUSTRY Appliance Store	
11. BIRTHPLACE (State or foreign country) Brunswick, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Cyrus Fisher		14. MOTHER'S MAIDEN NAME Laura V. Barger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-05-5199	
17. INFORMANT P. O. Box 599 Address Cumberland, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage & Hemiplegia DUE TO Rt. side Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerosis Cerebral and DUE TO General & Hypertension (c) General & Hypertension	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/18/58 , 19 58 , to 4/7/58 , 19 58 , that I last saw the deceased alive on 4/7/58 , 19 58 , and that death occurred at 4:55 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. Cumberland, Md. DATE SIGNED 4/7/58			
ACTUAL SIGNATURE Dr. Lee B. Mathews M.D.		49 Greene St. 4/7/58	
PHYSICIAN'S NAME (Type) Dr. Lee B. Mathews		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-9-1958	
22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		ADDRESS	
24a. REG'D BY REGISTRAR DATE APR 10 1958		24b. REGISTRAR'S SIGNATURE Chas. Smith	

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH BALTIMORE, MARYLAND		ALLEGEDLY 1933	
NAME OF DECEASED [Illegible]		SEX Male	
AGE [Illegible]		RACE White	
PLACE OF BIRTH [Illegible]		OCCUPATION [Illegible]	
RESIDENCE 130 VINELAND AVENUE BALTIMORE, MARYLAND		CAUSE OF DEATH [Illegible]	
DATE OF DEATH APRIL 10, 1933		TIME OF DEATH 11:00 A.M.	
PLACE OF DEATH [Illegible]		SIGNATURE OF PHYSICIAN [Illegible]	
SIGNATURE OF REGISTRAR [Illegible]		SIGNATURE OF WITNESSES [Illegible]	
CERTIFICATE OF DEATH [Illegible]		[Illegible]	

BURIAL V. S.

APR 10 1933

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4031

CERTIFICATE OF DEATH

04022

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE W. Va. b. COUNTY Morgan	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 2 wks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital		d. STREET ADDRESS Paw Paw, W. Va. 85x-3	
3. NAME OF DECEASED (Type or print) First Archie Middle Vanmeter Last Foltz		4. DATE OF DEATH Month 8 Day 10 Year 1958	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 29, 1908
9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR Months 9 Days 9 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Orchard	
11. BIRTHPLACE (State or foreign country) Hardy County, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Foltz		14. MOTHER'S MAIDEN NAME Lizzie Funkhouser	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 232-10-2514	
17. INFORMANT Bonnie S. Foltz, Paw Paw, W. Va.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 445x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Malignant Hypertension DUE TO (c) 9 months		INTERVAL BETWEEN ONSET AND DEATH 4 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-17 , 19 57 , to 4-8 , 19 58 , that I last saw the deceased alive on 4-7 , 19 58 , and that death occurred at 2:00 A.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 62 Greene Street DATE SIGNED	
ACTUAL SIGNATURE R. W. Ballin		M.D. 62 Greene Street	
PHYSICIAN'S NAME (Type) R. W. Ballin, M. D.		Cumberland, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/10/58	
22c. NAME OF CEMETERY OR CREMATORY Woodruff Church Cem.,		22d. LOCATION (City, town, or county) (State) Paw Paw, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Johnson		ADDRESS Berkeley Springs, W. Va.	
24a. REC'D BY REGISTRAR APR 17 '58		24b. REGISTRAR'S SIGNATURE Paul Smith	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		35		M		W		1928		MEMPHIS		TENNESSEE		UNITED STATES		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
APRIL 4, 1968		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		APRIL 4, 1968		MEMPHIS		MEMPHIS		TENNESSEE	
TIME OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		ORGAN OR PART AFFECTED		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
10:00 PM		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		HEART		APRIL 4, 1968		MEMPHIS		MEMPHIS		TENNESSEE	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
APRIL 4, 1968		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		APRIL 4, 1968		MEMPHIS		MEMPHIS		TENNESSEE	
TIME OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		ORGAN OR PART AFFECTED		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
10:00 PM		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		HEART		APRIL 4, 1968		MEMPHIS		MEMPHIS		TENNESSEE	

BUREAU M. E.

APR 17 1968

RECEIVED

FOR INFORMATION OF THE BUREAU OF VITAL STATISTICS, THE FOLLOWING INFORMATION IS SUBMITTED FOR THE DECEASED: JAMES EARL RAY, BORN APRIL 1928, MEMPHIS, TENNESSEE, DIED APRIL 4, 1968, MEMPHIS, TENNESSEE, CAUSE OF DEATH: HEART DISEASE, MANNER OF DEATH: NATURAL. THE DECEASED WAS A WHITE MALE, 35 YEARS OF AGE, SINGLE, AND A MEMBER OF THE METHODIST EPISCOPAL CHURCH. THE DECEASED WAS EMPLOYED AS A MEMBER OF THE CONGRESS. THE DECEASED WAS A RESIDENT OF MEMPHIS, TENNESSEE, AT THE TIME OF DEATH. THE DECEASED WAS A MEMBER OF THE CONGRESS. THE DECEASED WAS A RESIDENT OF MEMPHIS, TENNESSEE, AT THE TIME OF DEATH. THE DECEASED WAS A MEMBER OF THE CONGRESS. THE DECEASED WAS A RESIDENT OF MEMPHIS, TENNESSEE, AT THE TIME OF DEATH.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4032

CERTIFICATE OF DEATH

Reg. Dist. No. 04023

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 2HRS. 35MINS			
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle FRANCIS Last GALLAGHER SR.				4. DATE OF DEATH Month APRIL Day 4 Year 1958			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT 14, 1887	
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 70 Days 70 Hours 70 Min. 70		11. BIRTHPLACE (State or foreign country) MT. SAVAGE, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. AMERICA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sec. & Treas Water Co.				10b. KIND OF BUSINESS OR INDUSTRY Mt. Savage Water Co.			
13. FATHER'S NAME PATRICK GALLAHER				14. MOTHER'S MAIDEN NAME Adelaide STEPHENS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. A-540 207		17. INFORMANT MEMORIAL HOSPITAL Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Coronary Artery Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Sudden DUE TO (c) Since 1949				INTERVAL BETWEEN ONSET AND DEATH 1949			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 4-4-58 to 4-4-58 , that I last saw the deceased alive on 4-4-58 , and that death occurred at 3:45 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. F. Williams M.D.				ADDRESS (Street, city or town, state) Cumberland Md. 4558			
PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS				DATE SIGNED 122 So. Centre St.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 4/7/58		22c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cemetery	
22d. LOCATION (City, town, or county) (State) Mount Savage, Maryland				22e. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR APR 6 1958	
24b. REGISTRAR'S SIGNATURE Alfred Smith				24c. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1958

MASSACHUSETTS
BUREAU OF VITAL RECORDS

BUREAU V. B.

APR 8 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **04024**

4033

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural* Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 107 Mary St.		d. STREET ADDRESS R.F.D.#5 Locust Grove	
3. NAME OF DECEASED (Type or print) First Louis Middle Albert Last Garlick		4. DATE OF DEATH Month April Day 19 Year 19 58	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 16 1870
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired carman		10b. KIND OF BUSINESS OR INDUSTRY B&O R.Ry.	11. BIRTHPLACE (State or foreign country) Bedford Co, Pa,
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph Garlick	
14. MOTHER'S MAIDEN NAME Eva Price		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, not or unknown) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Susan Pryor-Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis with angina syndrome DUE TO (c) Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH sudden 1 yr ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Cumberland		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE H.V. Deming M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H.V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED April 20-1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/22/58	
22c. NAME OF CEMETERY OR CREMATORY St Lukes Cem.		22d. LOCATION (City, town, or county) (State) Cumberland Md	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.		24a. REC'D BY REGISTRAR Cumb Md	
24b. REGISTRAR'S SIGNATURE Alb...		DATE APR 22 '58	

FOR STATE
HEALTH DEPT.

MAINE STATE DEPARTMENT OF HEALTH - BATHSORE 11
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, age, sex, race, date of death, and cause of death. The form is partially filled out with handwritten text.

BUREAU V. 8

APR 22 1933

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4034 CERTIFICATE OF DEATH

Reg. Dist. No. 04025

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 8 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. STREET ADDRESS Bedford Road	
3. NAME OF DECEASED (Type or print) First CHARLES Middle T. Last GILLUM		4. DATE OF DEATH Month APRIL Day 19 Year 19 58	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 23, 1903
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months 5 Days 19 Hours 58 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Traffic Dept.		10b. KIND OF BUSINESS OR INDUSTRY CELANESE Corp.	
11. BIRTHPLACE (State or foreign country) BEDFORD, Co., Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DUNCAN GILLUM		14. MOTHER'S MAIDEN NAME BARBARA James	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-07-3508	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan , 19 58 , to April 19 , 19 58 , that I last saw the deceased alive on April 17 , 19 58 , and that death occurred at 12:25 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 441 N. Center St DATE SIGNED 4-20-58			
ACTUAL SIGNATURE William R. James M.D.		PHYSICIAN'S NAME (Type) DR. JAMES	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/21/58	
22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or county) (State) Bedford Rd. near Centerville, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DATE APR 23 '58		24b. REGISTRAR'S SIGNATURE W. Beach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

6032

PLACE OF DEATH HOME		SEX MALE		RACE WHITE	
CITY OR TOWN BALTIMORE		COUNTY BALTIMORE		STATE MARYLAND	
DATE OF DEATH APRIL 23, 1953		TIME OF DEATH 10:00 AM		PLACE OF INTERMENT GREENWICH CEMETERY	
NAME OF DECEASED JOHN EDWARD SMITH		DATE OF BIRTH JANUARY 15, 1900		PLACE OF BIRTH BALTIMORE, MARYLAND	
OCCUPATION LABORER		MARITAL STATUS SINGLE		CAUSE OF DEATH HEART DISEASE	
MEDICAL HISTORY NO PREVIOUS ILLNESS		MANNER OF DEATH NATURAL		SIGNATURE OF PHYSICIAN DR. J. H. SMITH	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESSES DR. J. H. SMITH, DR. J. D. JONES		SIGNATURE OF REGISTRAR MR. J. K. BROWN	

BUREAU V. S.

APR 23 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **04026**

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY

4035
Allegany

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE **W. Va.**

b. COUNTY **Mineral**

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland

c. LENGTH OF STAY IN 1b
5 weeks

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Ridgely

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Sacred Heart Hospital

d. STREET ADDRESS
Rt. #1

e. IS RESIDENCE ON A FARM?
YES ☐ NO ☒

3. NAME OF DECEASED
(Type or print)

First **Mary**

Middle **Ann**

Last **Goodrich**

4. DATE OF DEATH

Month **April**

Day **7**

Year **1958**

5. SEX

female

6. COLOR OR RACE

white

7. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

Sept. 28-1887

9. AGE (In years last birthday)

70 yrs.

IF UNDER 1 YEAR

Months **7** Days **19** Hours **58** Min.

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired-Registered nurse

10b. KIND OF BUSINESS OR INDUSTRY

Nursing

11. BIRTHPLACE (State or foreign country)

Mt. Savage, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Andrew Goodrich

14. MOTHER'S MAIDEN NAME

Jane Wilson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

No

16. SOCIAL SECURITY NO.

220-30-8472

17. INFORMANT

Scared Heart Hospital records.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

903.5

DUE TO

Traumatic shock due to fractured right radius and surgical neck of right femur.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

Also had myocarditis, generalized arterio-sclerosis, multiple furunculosis and varicose veins of both legs.

(c)

INTERVAL BETWEEN ONSET AND DEATH

5 weeks

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Lost balance and fell to the sidewalk

20c. TIME OF INJURY

Month, Day, Year

Hour **3-4**

p. m.

19 **58**

20d. INJURY OCCURRED

While at work ☐

Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

Sidewalk

20f. (City or town)

Cumberland, Allegany, Md.

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

H.V. Deming M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

April 8-1958

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

4/10/58

22c. NAME OF CEMETERY OR CREMATORY

St. George Episcopal Cemetery

22d. LOCATION (City, town, or county)

Mt. Savage Maryland

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Ruth E. Silcox

ADDRESS

Cumberland, Maryland

24a. REC'D BY REGISTRAR

APR 11 '58

24b. REGISTRAR'S SIGNATURE

Al H. Smith

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 11 1959

RECEIVED

484

CERTIFICATE OF DEATH

Reg. Dist. No. 04027

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 43 Westernport	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 301 Maryland Ave.		f. STREET ADDRESS 301 Maryland Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Ida First M Middle Greitzner Last		4. DATE OF DEATH Month April Day 26 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 20, 1884
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Charles Gwynn		14. MOTHER'S MAIDEN NAME Harriet Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Rexroad Brooks		Address 301 Md. Ave. Westernport, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Degeneration Not Specified as Rheumatic DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) chronic Myocarditis and Myocardial DUE TO (c) 2 years INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute Gastro-enteritis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 22, 1958 , to April 26, 1958 , that I last saw the deceased alive on April 25, 1958 , and that death occurred at 5:40 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Paul G. Wilson		DATE SIGNED 4-28-58	
PHYSICIAN'S NAME (Type) Piedmont, W. Va.		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 29, 1958	
22c. NAME OF CEMETERY OR CREMATORY Philos		22d. LOCATION (City, town, or county) (State) Westernport Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. S. Bral - Westernport, Md.		24a. REC'D BY REGISTRAR DATE MAY 1 '58	
24b. REGISTRAR'S SIGNATURE Reber			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4036

CERTIFICATE OF DEATH

Reg. Dist. No. 04028

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 408 Leghish St.,		d. STREET ADDRESS 408 Lehigh St.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EARL Middle NOAH Last HAGER		4. DATE OF DEATH Month April Day 28, Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1895
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bottling House Foreman		10b. KIND OF BUSINESS OR INDUSTRY Queen City Brewery	
11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Martin H. Hager		14. MOTHER'S MAIDEN NAME Bertha Long	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes,		16. SOCIAL SECURITY NO. W. W. # 1 214-05-4921	
17. INFORMANT Joseph M. Hager		Address 305 Polk St., Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of the right lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 6 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 1-18- , 19 58 , to 4-27- , 19 58 , that I last saw the deceased alive on 4-27- , 19 58 , and that death occurred at 12:50 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 57 Greene St., DATE SIGNED 4/30/58 ACTUAL SIGNATURE L. Lewis PHYSICIAN'S NAME (Type) Dr. Lewis Brings Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/1/58	22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DATE MAY 2 '58		24b. REGISTRAR'S SIGNATURE Overman	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

437

CERTIFICATE OF DEATH

Reg. Dist. No.

04029

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle W. Last Hamilton				4. DATE OF DEATH Month April Day 16 Year 1958			
5. SEX Male		6. COLOR OR RACE Color		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/17/58	
9. AGE (In years last birthday) 1 yrs.		IF UNDER 1 YEAR Months 1 Days 16 Hours 19 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James Hamilton				14. MOTHER'S MAIDEN NAME Delina Rhodes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. Chart		17. INFORMANT Chart			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, bilateral 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/14 , 19 58 , to 4/16 , 19 58 , that I last saw the deceased alive on 4/16 , 19 58 , and that death occurred at 3:05 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 456 N. Center Street DATE SIGNED 4/17/58							
ACTUAL SIGNATURE Geo. H. Lenz Jr.		M.D.					
PHYSICIAN'S NAME (Type) Dr. L.H. Lenz		456 N. Center Street					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/18/58		22c. NAME OF CEMETERY OR CREMATORY S.S. Peter & Paul Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Haper		ADDRESS Cumberland Md.		24a. REC'D BY REGISTRAR APR 22 '58		24b. REGISTRAR'S SIGNATURE W. H. Leach	

2060173 XV5

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - EATON, 10

BUREAU V. 1

APR 22 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

04030

4085

FOR STATE
HEALTH DEPT.

M

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 6 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miners Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edward V. Henckel		4. DATE OF DEATH Month April Day 1 Year 19 58	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 28-1875
9. AGE (in years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 19 Min. 58	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired-paymaster, Am. Coal Co.		10b. KIND OF BUSINESS OR INDUSTRY Wellersburg, Pa.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Valentine Henckel		14. MOTHER'S MAIDEN NAME Kathryn Snyder	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 282-05-0756	
17. INFORMANT Miners Hospital records.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 903.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Traumatic pneumonitis (c) a fall also had arteriosclerosis.		INTERVAL BETWEEN ONSET AND DEATH Gradual 6 days 8 days ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) *Fractured ribs* (10 ribs)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. against a chair.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shaving, lost balance, fell, struck left side of chest	
20c. TIME OF INJURY Month, Day, Year 10.30 March 22 19 58		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Mt. Savage, Allegany, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE H. V. Deming M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H.V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED April 2-1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 4 -58	
22c. NAME OF CEMETERY OR CREMATORY St. Patricks Cemetery		22d. LOCATION (City, town, or county) (State) Mt. Savage, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.R. Durst		ADDRESS Frostburg, Md.	
24a. REC'D BY REGISTRAR APR 7 '58		24b. REGISTRAR'S SIGNATURE W. H. Jones	

STATE OF TEXAS
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH



RECEIVED
APR 7 1959
BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

438

CERTIFICATE OF DEATH

Reg. Dist. No. 04031

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 6/5/57	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Thomas Last Hodel		4. DATE OF DEATH Month April Day 9 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/14/1871
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Laborer		10b. KIND OF BUSINESS OR INDUSTRY B.&O. R. R.	
11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Mary Ann Hodel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT P.O. Box 599 Address Cumberland, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis, Chronic degenerative DUE TO (b) Hypertension & Coraive Hypertrophy DUE TO (c) Sclerosis & Arterio Sclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from 6/5/57 , 19____, to 4/9/58 , 19____, that I last saw the deceased alive on 4/9/58 , 19____, and that death occurred at 11:40 AM , from the causes and on the date stated above.	
ACTUAL SIGNATURE Lee Mathews M.D.		ADDRESS (Street, city or town, state) 49 Green Street DATE SIGNED 4/10/58	
PHYSICIAN'S NAME (Type) Dr. Lee B. Mathews		Cumberland, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-12, 1958	
22c. NAME OF CEMETERY OR CREMATORY St. Peter & Paul Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE APR 14 '58	
24b. REGISTRAR'S SIGNATURE W. J. Leach			

CERTIFICATE OF DEATH

NAME		John	
AGE		100	
SEX		Male	
RACE		White	
DATE OF BIRTH		1890	
PLACE OF BIRTH		Maryland	
DATE OF DEATH		1950	
PLACE OF DEATH		Baltimore	
CAUSE OF DEATH		Heart Disease	
MANNER OF DEATH		Natural	
SIGNATURE		[Signature]	
DATE		1950	
PLACE		Baltimore	
OFFICIAL		[Signature]	
DATE		1950	
PLACE		Baltimore	

BUREAU V. S.

APR 14 1950

RECEIVED

4939

CERTIFICATE OF DEATH

Reg. Dist. No. 04032

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>215 Wallace St.</u>				d. STREET ADDRESS <u>1 215 Wallace St</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>H.</u> Last <u>Howard</u>				4. DATE OF DEATH Month <u>Apr.</u> Day <u>12</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 8, 1869</u>	
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Stationary Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tanning Co</u>		11. BIRTHPLACE (State or foreign country) <u>New Orleans</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mrs. Marion Miles</u>		Address <u>Cumb. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocarditis chronic degeneration</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Arterio-Sclerosis, Senile,</u> (c) <u>with Hypertension</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr 8, 1958</u> to <u>Apr 12, 1958</u> that I last saw the deceased alive on <u>Apr 12, 1958</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>DR. E. B. M... 49 Greene Street</u>				ADDRESS (Street, city or town, state) <u>49 Greene St</u>		DATE SIGNED <u>4/14/58</u>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4/15/58</u>		<u>Woodlawn Cem.</u>		<u>Cumberland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u>				ADDRESS <u>Cumb. Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 16 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. L. ...</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Figure 1

APR 16 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

440

CERTIFICATE OF DEATH

04033

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>	
c. LENGTH OF STAY IN 1b <u>6 yrs. Lifetime</u>		d. STREET ADDRESS <u>451 Goethe Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>451 Goethe St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>SALEY HUMBERTSON</u>		4. DATE OF DEATH Month Day Year <u>4 13 19 58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-30-1862</u>
9. AGE (In years last birthday) <u>95</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal Mines</u>	
11. BIRTHPLACE (State or foreign country) <u>Shaft, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm. Humbertson</u>		14. MOTHER'S MAIDEN NAME <u>Mary Twigg</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Emory Perkins, Midland, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic Heart Disease & Failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Years -</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/21</u> , 19 <u>48</u> , to <u>4/13</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4/13</u> , 19 <u>58</u> , and that death occurred at <u>4:00</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>John B. Davis, M.D.</u>		22. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
PHYSICIAN'S NAME (Type) <u>John B. Davis, M.D. Frostburg, Md.</u>		22b. DATE THEREOF <u>4/15/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Park Frostburg, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Benjamin H. Montanant</u>		23b. ADDRESS <u>Hafer Funeral Home</u>	
24a. REC'D BY REGISTRAR <u>APR 17 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

RECEIVED

APR 17 1938

BURKLAU M. E.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

441

CERTIFICATE OF DEATH

04034

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	c. LENGTH OF STAY IN 1b 02 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 401 Pennsylvania Avenue		d. STREET ADDRESS 401 Pennsylvania Avenue	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) ALICE LOUISA JOHNSON		4. DATE OF DEATH Month April Day 22 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 8, 1897
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Homd	11. BIRTHPLACE (State or foreign country) Marquess, West Virginia
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles N. Huffman	
14. MOTHER'S MAIDEN NAME Charles Ida Wolfe		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT John T. Johnson	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Trauma 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of uterus DUE TO (c) 4 mon		INTERVAL BETWEEN ONSET AND DEATH 3 mks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb. 15, 1958 , to Apr. 22, 1958 , that I last saw the deceased alive on Apr. 16, 1958 , and that death occurred at 11:25 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Clay E. Durrett		ADDRESS (Street, city or town, state) 236 Va. Ave. Cumberland, Md.	
PHYSICIAN'S NAME (Type) Clay E. Durrett, M.D.		DATE SIGNED 4/24/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Apr. 25, 1958	22c. NAME OF CEMETERY OR CREMATORY Evansville Cemetery	22d. LOCATION (City, town, or county) (State) Evansville, West Virginia
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR APR 28 '58	24b. REGISTRAR'S SIGNATURE Deborah

WILLIAM BOND

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
CERTIFICATE OF DEATH

BUREAU V. S.

APR 28 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4042

CERTIFICATE OF DEATH

Reg. Dist. No. 04035

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 1yr. 3mo. 2da.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sylvan Retreat		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anna Middle Dorsey Last Johnson		4. DATE OF DEATH Month April Day 27 Year 1958	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 23, 1892
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 6 Days 5 Hours 0 Min. 0	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Phillip Dorsey		14. MOTHER'S MAIDEN NAME Elizabeth Jackson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-30-1033	
17. INFORMANT Mrs. Estella Taylor		Address Frostburg, Md. 142 Mechanic St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420 Coronary Thrombosis DUE TO (b) 450 General Arteriosclerosis DUE TO (c) 290 Pernicious Anemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH Stricken ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 301 Toxic Depressive Reaction			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 25, 1957 to Apr. 27, 1958 , that I last saw the deceased alive on April 26, 1958 , and that death occurred at 6:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. McLean (M.D.)		ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 4-28-58	
PHYSICIAN'S NAME (Type) James E. McLean, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-30-1958	
22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Pk.		22d. LOCATION (City, town, or county) (State) Frostburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C. H. Mattingly ADDRESS Hafer Funeral Home Frostburg, Md.		24a. REC'D BY REGISTRAR DATE MAY 5 '58	
		24b. REGISTRAR'S SIGNATURE W. H. Beach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Allegation of Cause of Death: *Allegation of Cause of Death*

Underlying Cause of Death: *Underlying Cause of Death*

Immediate Cause of Death: *Immediate Cause of Death*

Place of Death: *Place of Death*

Age: *Age*

Sex: *Sex*

Color: *Color*

Marital Status: *Marital Status*

Female

Colored

June 23, 1992

65

Housewife

Worcester

Philip Dorsey

Elizabeth Jackson

11-9-1957

Kathleen

11-9-1957

Signature of Registrar

Signature of Physician

Signature of Medical Examiner

Signature of Coroner

Signature of Jury

Signature of Witnesses

Signature of Death Certificate

Signature of Death Certificate

Signature of Death Certificate

Signature of Death Certificate

Signature of Death Certificate

Signature of Death Certificate

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

443

CERTIFICATE OF DEATH

Reg. Dist. No. 04036

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 13 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle M. Last JOHNSON		4. DATE OF DEATH Month APRIL Day 18 Year 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 23 1892
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) VALE SUMMIT, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME HENRY CAIN		14. MOTHER'S MAIDEN NAME MARY BRADY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Embolus Post Operative DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Large Multiple Ventral Hernia			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2 Apr 1958 to 18 Apr 1958 that I last saw the deceased alive on 18 Apr 1958 and that death occurred at 5:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Fuller B Whitworth M.D.		ADDRESS (Street, city or town, state) Cumberland Md DATE SIGNED 19 Apr 1958	
PHYSICIAN'S NAME (Type) DR. FULLER WHITWORTH			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-21-58	
22c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		24a. REC'D BY REGISTRAR DATE APR 22 '58	
24b. REGISTRAR'S SIGNATURE W. B. Smith			

444

CERTIFICATE OF DEATH

04037

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b 24 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				d. STREET ADDRESS 229 Emily Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle A. Last JONES				4. DATE OF DEATH Month April Day 8 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/31/85		9. AGE (In years lost birthday) yrs. 72	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardener		10b. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) Wales - Cardiff		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Jones				14. MOTHER'S MAIDEN NAME Mary Ann Pryor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Pt.'s Chart - Sacred Heart Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of rectum 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) / DUE TO (c) /						INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3-20 , 19 58 , to 4-8 , 19 58 , that I last saw the deceased alive on 4-8-58 , 19 58 , and that death occurred at 1203 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 57 Greene St. Cumberland Md DATE SIGNED 4-10-58							
ACTUAL SIGNATURE L. Brings				M.D. 57 Greene St. Cumberland Md			
PHYSICIAN'S NAME (Type) Dr. L. Brings				57 Greene Street			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-11-1958		22c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				24a. REC'D BY REGISTRAR APR 14 '58		24b. REGISTRAR'S SIGNATURE Alfred Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

APR 14 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

445

CERTIFICATE OF DEATH

Reg. Dist. No.

04038

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		d. STREET ADDRESS 11 Marion Street	
3. NAME OF DECEASED (Type or print) First LEMUEL Middle SAMUEL Last KELSO		4. DATE OF DEATH Month April Day 2 Year 1958	
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 27, 1871
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer General Farming		11. BIRTHPLACE (State or foreign country) Hampshire County, West Va.	
13. FATHER'S NAME James Kelso		14. MOTHER'S MAIDEN NAME Minerva Spaid	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		17. INFORMANT Mrs. Leona Webster	
16. SOCIAL SECURITY NO.		Address 11 Marion St. Cumberland, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis (generalized) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 year 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-4 , 19 56 to 4-2 , 19 58 , that I last saw the deceased alive on 4-1 , 19 58 , and that death occurred at 11 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE L. Brings		DATE SIGNED 4-2-58	
PHYSICIAN'S NAME (Type) L. Brings		M.D. 57 Greene St., Cumberland, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 5, 1958	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR DATE APR 7 1958	
		24b. REGISTRAR'S SIGNATURE	

APR 7 1958

RECEIVED
JUL 19 1958

CERTIFICATE OF DEATH

04039

Reg. Dist. No.

4046

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN lb 7 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS ELLERSLIE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MARGARET Middle E. Last LAFFERTY				4. DATE OF DEATH Month APRIL Day 16 Year 1958			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 15 Aug. 23, 1880 78	
9. AGE (In years last birthday)		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Housework		11. BIRTHPLACE (State or foreign country) PENNA	
13. FATHER'S NAME HENRY OSTER				14. MOTHER'S MAIDEN NAME ELIZABETH BINGHAM			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 215-07-3002			
17. INFORMANT Address James O. Lafferty Ellerslie, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) acute cerebro-vascular accident DUE TO (b) 15 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Apr 1 , 19 58 , to Apr 16 , 19 58 , that I last saw the deceased alive on Apr 16 , 19 58 , and that death occurred at 12:45 PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE John A. Topper M.D. Hyndman Pa				ADDRESS (Street, city or town, state) 4/16/58			
PHYSICIAN'S NAME (Type) JOHN A. TOPPER				John A. Topper MD Hyndman Pa			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 19, 1958		22c. NAME OF CEMETERY OR CREMATORY Pleasant Ridge		22d. LOCATION (City, town, or county) (State) Buffalo Mills, Pa. RD 1	
23. FUNERAL DIRECTOR'S SIGNATURE Edward H. Seigler ADDRESS Hyndman, Pa.				24a. REC'D BY REGISTRAR APR 21 58		24b. REGISTRAR'S SIGNATURE W. Seigler	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and location. The text is mostly illegible due to blurring and bleed-through.

BUREAU V. S.

APR 21 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04040

4047

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 45 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 508 Sheridan Place		d. STREET ADDRESS 508 Sheridan Place	
3. NAME OF DECEASED (Type or print) First George Middle C. Last Maguire		4. DATE OF DEATH April 19, 19 58	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 22, 1897
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst Car Foreman		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Allegany, N.Y.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Maguire		14. MOTHER'S MAIDEN NAME Margaret Whalley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 705-09-9698	
17. INFORMANT Mary Kifer Maguire		Address 508 Sheridan Place	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO 241X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchial Asthma DUE TO (c) Myocarditis			INTERVAL BETWEEN ONSET AND DEATH 241X 8 yrs. 5 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1954 to Apr. 20, 1958 , that I last saw the deceased alive on Apr. 12, 1958 , and that death occurred at 9:10 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Clay E. Durrett M.D.		ADDRESS (Street, city or town, state) Cumberland, Md DATE SIGNED 4/21/58	
PHYSICIAN'S NAME (Type) Clay E. Durrett 236 Virginia Ave. Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-23-58	
22c. NAME OF CEMETERY OR CREMATORY At. Marys Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md	
24a. REC'D BY REGISTRAR DATE APR 23 '58		24b. REGISTRAR'S SIGNATURE Rebecca	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13

BUREAU V. 1

APR 23 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4048 CERTIFICATE OF DEATH

Reg. Dist. No.

04041

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 26 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle WEBSTER Last MAHANEY				4. DATE OF DEATH Month 4 Day 15 Year 1958			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-16-1870	
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Brakeman				10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME NATHAN MAHANEY				14. MOTHER'S MAIDEN NAME SARAH SCHMIDT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 705-07-9525		17. INFORMANT Mrs. Flora Mae Brown, Cumberland, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592x DUE TO Chronic Nephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 3 days DUE TO 3 yrs. (c) Myocardial Degeneration							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m. —				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 2/12/56 , 19___, to 4/15/58 , 19___, that I last saw the deceased alive on 4/15/58 , 19___, and that death occurred at 10:12 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland DATE SIGNED 4/16/58							
ACTUAL SIGNATURE DR. R. J. WILLIAMS M.D.							
PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-18-58		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				ADDRESS		24a. REC'D BY REGISTRAR DATE APR 18 '58	
						24b. REGISTRAR'S SIGNATURE W. J. Church	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ALLIANCE STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

BUREAU V. S.

APR 15 1952

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4101

CERTIFICATE OF DEATH

04042

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 11 mo., 25 das.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sylvan Retreat		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lincoln Middle A. Last Martz		4. DATE OF DEATH Month April Day 20 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 23, 1862
9. AGE (In years last birthday) 95 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Herman Martz		14. MOTHER'S MAIDEN NAME (Unknown) Ringler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Homer Martz, Rt 3, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 Chronic Myocarditis DUE TO (b) 366 Cerebral Arteriosclerosis DUE TO (c) Senile Deterioration		INTERVAL BETWEEN ONSET AND DEATH ? ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Box Senile psychosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 26, 19 57 to April 20, 19 58 , that I last saw the deceased alive on April 19, 19 58 , and that death occurred at 2:50 P. from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. McLean M.D.		DATE SIGNED 4/21/58	
PHYSICIAN'S NAME (Type) James E. McLean, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 23/58	22c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery	22d. LOCATION (City, town, or county) (State) Glenco Penna
23. FUNERAL DIRECTOR'S SIGNATURE Timothy Konhaus		ADDRESS Meyersdale, Pa.	
24a. REC'D BY REGISTRAR APR 23 '58		24b. REGISTRAR'S SIGNATURE W. H. Beach	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Compassionate, I, the undersigned, do hereby certify that the above named person died on the 1st day of April, 1958, at the residence of the deceased, 1234 Main Street, New York, New York.

Sylvan Harris

Almon

John

John

John

John

John

John

John

John

BUREAU Y. S.

APR 23 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

449

Item 7 Film G228 5-15-58 et

CERTIFICATE OF DEATH

Reg. Dist. No.

04043

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>BARTON MARYLAND</u> b. COUNTY <u>ALLEGANY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GIMBERLAND</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BARTON</u>	
c. LENGTH OF STAY IN 1b <u>6 DAYS</u>		d. STREET ADDRESS <u>SACRED HEART HOSPITAL</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SACRED HEART HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>M</u> Last <u>McCORMICK</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>20</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/14, 1882</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSEPH MCCORMICK</u>		14. MOTHER'S MAIDEN NAME <u>JANE?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>PTS. CHART.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GANGRENE LEFT LEG & FOOT</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>EMBOLISM LEFT POPLITEAL ARTERY</u> DUE TO <u>ARTERIOSCLEROTIC HEART DISEASE—WITH</u> (c) <u>ARRHYTHMIC FIBRILLATION</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>14 days</u> <u>1 year</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>GENERAL ARTERIOSCLEROSIS</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/14</u> , 19 <u>58</u> , to <u>3/20</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3/20</u> , 19 <u>58</u> , and that death occurred at <u>5:30 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>59 Greene ST</u> DATE SIGNED <u>3/22/58</u>			
ACTUAL SIGNATURE <u>SG Weisman</u> M.D.		PHYSICIAN'S NAME (Type) <u>SG WEISMAN MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/23/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Moscow Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Es Roal - Westernport, Md</u>		24a. REC'D BY REGISTRAR DATE <u>APR 2 4 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. E. Beach</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 27 1958

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital, or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4023

CERTIFICATE OF DEATH

Reg. Dist. No. 04011

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,				c. LENGTH OF STAY IN 1b 2 HRS. 10 MIN. X		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RAWLINGS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS 7		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIDDLE Last BABY BOY MC CUSKER			4. DATE OF DEATH Month Day Year APRIL 26 19 58				
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 26, 1958		9. AGE (In years last birthday) yrs. 2 10	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME OLIVER D. MC CUSKER				14. MOTHER'S MAIDEN NAME LORENA HAMPTON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X DUE TO Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 2:50 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Dr. F.B. Whitworth M.D. Cumberbund Md 28 Apr 58 PHYSICIAN'S NAME (Type) DR. F.B. WHITWORTH							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 4-27-58		22c. NAME OF CEMETERY OR CREMATORY Memorial Hospital		22d. LOCATION (City, town, or county) (State) Cumberland Md	
23. FUNERAL DIRECTOR'S SIGNATURE Memorial Hospital, Cumberland, Maryland.				24a. REC'D BY REGISTRAR DATE MAY 1 '58		24b. REGISTRAR'S SIGNATURE W. Search	

2060212XVO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4950

CERTIFICATE OF DEATH

Reg. Dist. No. 04044

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN TB 9 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
f. STREET ADDRESS 604 Woodlawn, Terrace		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Dominick Middle Arnold Mc Greevy		4. DATE OF DEATH Month April Day 29 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/13/94
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months 63 Days 29 Hours 19 Min. 58	IF UNDER 24 HRS. Hours 19 Min. 58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver		10b. KIND OF BUSINESS OR INDUSTRY Newspaper	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Mc Greevy Mc Greevy		14. MOTHER'S MAIDEN NAME Nancy Arnold	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) yes (If yes, give war or dates of service) War I		16. SOCIAL SECURITY NO. Pt's chart.	
17. INFORMANT Pt's chart.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hemorrhage 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bronchogenic Carcinoma DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 9 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/20 , 19 58 , to 4/29 , 19 58 , that I last saw the deceased alive on 4/28 , 19 58 , and that death occurred at 11:00 A. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Leo H. Ley Jr. M.D.		ADDRESS (Street, city or town, state) 456 N. Centre St DATE SIGNED 4/29/58	
PHYSICIAN'S NAME (Type) LEO H. LEY JR. M.D.		Cumberland Ind.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 2, 1958	22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR 2 58 DATE MAY		24b. REGISTRAR'S SIGNATURE W. J. Smith	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4102 CERTIFICATE OF DEATH

Reg. Dist. No. 04045

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LaVale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LaVale</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>719 LaVale Terrace.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Howard Louis Mignot</u>				4. DATE OF DEATH Month Day Year <u>April 15, 19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 12, 1899</u>		9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Yard Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Western Md. R. R.</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles L. Mignot</u>				14. MOTHER'S MAIDEN NAME <u>Annie Greider</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>705-10-6364</u>		17. INFORMANT Address <u>Mrs. Howard Mignot, 719 LaVale Terr. LaVale, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u> DUE TO <u>Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>Since 12-12-56</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-12-56</u> , 19 <u>56</u> , to <u>4-15-58</u> , that I last saw the deceased alive on <u>4-9-58</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. F. Williams</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>Cumberland Md 4-15-58</u>			
PHYSICIAN'S NAME (Type) <u>William F. Williams, M. D.</u>				<u>Cumberland, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 17, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Eckhart Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Eckhart, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George, Cumberland, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 17 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Paul</u>	

BUREAU V. S.

RECEIVED

NOV 17 1958

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4051

CERTIFICATE OF DEATH

Reg. Dist. No.

04046

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 5 1/2 HOURS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LONA CONING, MD.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS 3 WEST MAIN STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BABY Middle GIRL Last MILLER				4. DATE OF DEATH Month APRIL Day 17 Year 58			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 17, 1958	
9. AGE (In years last birthday) 5 1/2 HRS. XX		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME EARL C. MILLER				14. MOTHER'S MAIDEN NAME KAEFER, ANN ELIZABETH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity (21 wks) 776x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 4/17/58 to 4/17/58 , that I last saw the deceased alive on 4/17/58 , and that death occurred at 7:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, State) Cumberland, Md. DATE SIGNED 4/15/58 ACTUAL SIGNATURE W.P. Hodges M.D. PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF April 18, 1958		22c. NAME OF CEMETERY OR CREMATORY Memorial Hospital		22d. LOCATION (City, town, or county) (State) Cumberland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE 2060323XVO				24a. REC'D BY REGISTRAR APR 28 '58		24b. REGISTRAR'S SIGNATURE W.P. Hodges	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HENRY		45		M		W		JAN 1 1880		NEW YORK		NEW YORK		NEW YORK	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE		COUNTRY OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
MARRIED		JAN 1 1910		NEW YORK		NEW YORK		NEW YORK		JAN 1 1920		NEW YORK		NEW YORK	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
HEART DISEASE		NATURAL		NEW YORK		NEW YORK		NEW YORK		JAN 1 1920		NEW YORK		NEW YORK	
SIGNATURE OF PHYSICIAN		DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE		COUNTRY OF SIGNATURE		DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE	
JAMES H. HENRY		JAN 1 1920		NEW YORK		NEW YORK		NEW YORK		JAN 1 1920		NEW YORK		NEW YORK	
SIGNATURE OF REGISTRAR		DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE		COUNTRY OF SIGNATURE		DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE	
JAMES H. HENRY		JAN 1 1920		NEW YORK		NEW YORK		NEW YORK		JAN 1 1920		NEW YORK		NEW YORK	

BUREAU V. 3.

APR 20 1920

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4052

CERTIFICATE OF DEATH

Reg. Dist. No.

04047

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>704 Frederick Street</u>				d. STREET ADDRESS <u>704 Frederick St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Clement</u> Middle <u>H.</u> Last <u>MILLER</u>				4. DATE OF DEATH Month <u>April</u> Day <u>28</u> Year <u>19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 3, 1893</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>B. & O.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Henry C. Miller</u>				14. MOTHER'S MAIDEN NAME <u>Mary K. Siehl</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>705 09 8672</u>		17. INFORMANT Address <u>Emma E. Miller, Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 HRS.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Last hours to 10:20 P.M.</u> to <u>10:20 P.M.</u> 19 <u>55</u> , that I last saw the deceased alive on <u>10.20.1955</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wm. F. Williams</u> M.D. <u>Cumberland Md.</u>				DATE SIGNED <u>4-29-58</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>							
22b. DATE THEREOF <u>May 1, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hyndman Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hyndman, Pa.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Kight</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 1 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Robert Smith</u>			

50

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4986

CERTIFICATE OF DEATH

Reg. Dist. No. 04048

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. LENGTH OF STAY IN lb <u>Lifetime</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>330 E. Main Street</u>		d. STREET ADDRESS <u>330 E. Main Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Eliza</u> Middle <u>A.</u> Last <u>Miller</u>		4. DATE OF DEATH Month <u>4</u> Day <u>II</u> Year <u>1958</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 21 1864</u>
9. AGE (In years last birthday) <u>94</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Zihlman Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Jobe Stevens</u>		14. MOTHER'S MAIDEN NAME <u>Agnes Stephens</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address <u>Md.</u> <u>Mrs. Grace Mont, 330 E. Main St. Frostburg</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Dis.</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>24 yrs.</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 11, 1958</u> , to <u>April 11, 1958</u> , that I last saw the deceased alive on <u>April 11, 1958</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John C. Owens</u> M.D.		ADDRESS (Street, city or town, state) <u>134 E Main</u> DATE SIGNED <u>4/13/58</u>	
PHYSICIAN'S NAME (Type) <u>John C. Owens</u>		<u>Frostburg, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-14-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Pk.</u>	22d. LOCATION (City, town, or county) (State) <u>Frostburg Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Halter Funeral Home</u> ADDRESS <u>Frostburg, Md.</u>		24a. REC'D BY REGISTRAR <u>APR 17 58</u>	24b. REGISTRAR'S SIGNATURE <u>W. H. French</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF ILLINOIS - DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

DECEASED
CIVILIAN
IN HOME

100

*Specimen for examination
Preserved - Heart & Lungs*

BUREAU M. I.

APR 17 1969

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04049

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b X Lonaconing	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jessie Middle Waddell Last Miller		4. DATE OF DEATH Month April Day 14 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 20, 1874 83 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	9. AGE (In years last birthday) 83 yrs.
11. BIRTHPLACE (State or foreign country) Lonaconing, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Waddell		14. MOTHER'S MAIDEN NAME Jessie Graham	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. William Ternent		Address Lonaconing, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 "Daughter" Acute left heart failure; myocarditis 3 days DUE TO (b) Chronic congestive heart failure years DUE TO (c) Atherosclerosis years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Emphysema			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec. 14, 1958 to April 14, 1958 , that I last saw the deceased alive on April 14, 1958 , and that death occurred at 2 p. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Lonaconing, Md. DATE SIGNED Leslie R. Miles, Jr.			
ACTUAL SIGNATURE Leslie R. Miles, Jr. M.D.			
PHYSICIAN'S NAME (Type) Leslie R. Miles, Jr., M.D. Lonaconing, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/17/58	22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery	22d. LOCATION (City, town, or county) (State) Lonaconing, Md.
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		24a. REC'D BY REGISTRAR APR 18 1958	24b. REGISTRAR'S SIGNATURE DeLoach

BUREAU V. S.

RECEIVED

APR 10 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4053

CERTIFICATE OF DEATH

04050

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Baltimore Pike- Cumberland, Md		/ d. STREET ADDRESS Baltimore Pike-Cumberland, Md	
3. NAME OF DECEASED (Type or print) First Ludovicus Middle Miller Last Miller		4. DATE OF DEATH Month April Day 6 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 25, 1861
9. AGE (In years last birthday) 96 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Keeper		10b. KIND OF BUSINESS OR INDUSTRY At home	
11. BIRTHPLACE (State or foreign country) Bedford County Pa.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME John P. Morse		14. MOTHER'S MAIDEN NAME Susanna Clingerman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Roy C. Miller		Address Cumberland, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDITIS, WITH CONGESTIVE FAILURE 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROSIS, GENERALIZED DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS 7	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JUNE , 19 57 , to APRIL , 19 58 , that I last saw the deceased alive on 4.2.58 , and that death occurred at 1:45AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE William K. James M.D. 441 N. CENTRE ST 4.7.58 PHYSICIAN'S NAME (Type) W. P. JAMES, M. D. CUMBERLAND, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/8/58	
22c. NAME OF CEMETERY OR CREMATORY Pleasant Grove		22d. LOCATION (City, town, or county) (State) Cumberland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox		ADDRESS Cumberland, Maryland	
24a. REC'D BY REGISTRAR DATE APR 9 '58		24b. REGISTRAR'S SIGNATURE W. P. James	

CERTIFICATE OF DEATH

STATE DEPARTMENT OF HEALTH - BALTIMORE 10

BUREAU V. 2

APR 9 1958

RECEIVED

NAME OF DECEASED JAMES EARL RAY		DATE OF BIRTH 10-3-1928		PLACE OF BIRTH MOBILE, ALABAMA	
SEX MALE		RACE WHITE		EDUCATION HIGH SCHOOL	
OCCUPATION None		MARRIAGE None		RELIGION None	
DATE OF DEATH 4-4-68		PLACE OF DEATH MEMPHIS, TENNESSEE		CAUSE OF DEATH MURDER	
MANNER OF DEATH HOMICIDE		CERTIFICATE NO. 100-434340		FILE NO. 100-434340	
SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF PHYSICIAN	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	



THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE DEATH RECORD ACT OF 1953, CHAPTER 10, SECTION 10-101, BALTIMORE, MARYLAND.

- 04051
Reg. Dist. No.

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
5M 2/57

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Klondike Frostburg		c. LENGTH OF STAY IN 1b X		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Klondike	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miners Hospital			d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Mary		First Ada		Middle Miller	
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Sept. 18-1902		9. AGE (in years last birthday) 55 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Carls, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James Winter	
14. MOTHER'S MAIDEN NAME Elizabeth Densmore		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT (nephew) Wm. Yates, Carlos, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage (apoplexy) about 3 hrs. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 331x DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Frostburg, Md.		20g. (County) Allegany		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE H. V. Deming M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED April 9-1958	
EXAMINER'S NAME (Type) H. V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/11/58		22c. NAME OF CEMETERY OR CREMATORY Memorial Park	
22d. LOCATION (City, town, or county) Frostburg, Md.		22e. (State) Md.		22f. (Country) U.S.A.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, Md.		24a. REC'D BY REGISTRAR APR 14 '58	
24b. REGISTRAR'S SIGNATURE [Signature]		24c. (City, town, or county) Frostburg, Md.			

FOR STATE
HEALTH DEPT.

1958
APR 14 1958
RECEIVED

BUREAU V. 8

APR 14 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4054

CERTIFICATE OF DEATH

04052

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 1 DAY			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND,				d. STREET ADDRESS 1 217 RACE STREET			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last AGNES REGINA MORELAND				4. DATE OF DEATH Month Day Year APRIL 6 1958			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 19, 1887	
9. AGE (In years lost birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE & Grocery Clerk				10b. KIND OF BUSINESS OR INDUSTRY CUMBERLAND, MARYLAND			
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JOHN THOMAS GRIFFIN				14. MOTHER'S MAIDEN NAME LAURA JOHNSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 214-32-3272B			
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Thrombia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) myocarditic Decomposition DUE TO (c) Hypertension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) INTERVAL BETWEEN ONSET AND DEATH 2 wks 2 yr 8 yr							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While Not while of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 1952 to Apr. 6, 1958 , that I last saw the deceased alive on Apr. 5, 1958 , and that death occurred at 12:38 A. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 236 W. in Cumberland DATE SIGNED 4/6/58 ACTUAL SIGNATURE Clay G. Durrett M.D. PHYSICIAN'S NAME (Type) DR. CLAY DURRETT							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 4-8-58		22c. NAME OF CEMETERY OR CREMATORY St. Mary Cemetery	
22d. LOCATION (City, town, or county) (State) Cumberland, Md.							
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				24a. REC'D BY REGISTRAR APR 9 '58		24b. REGISTRAR'S SIGNATURE Decker	
ADDRESS Cumberland, Md.							

CERTIFICATE OF DEATH

Form 100-10-100

BUREAU V. S.

APR 9 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

455

CERTIFICATE OF DEATH

04053

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 7/31/57	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland		d. STREET ADDRESS 603 Leiper Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle W. Last Morgan		4. DATE OF DEATH Month April Day 26 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/18/1870
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Saw Mill Worker		10b. KIND OF BUSINESS OR INDUSTRY Worker	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Samuel Morgan		14. MOTHER'S MAIDEN NAME Mary Robertson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT P. O. Box 599 Address Cumberland, Md.		18. ALLEGANY COUNTY INFIRMARY RECORDS	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 422.2 IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Cerebral arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis DUE TO (c) Sudden INTERVAL BETWEEN ONSET AND DEATH ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Left Hemiplegia			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 7/31/57 , 19, to 4/26/58 , 19, that I lost saw the deceased alive on 4/26/58 , 19, and that death occurred at 3:40 P M, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) 49 Greene Street DATE SIGNED 4/28/58			
ACTUAL SIGNATURE James E. McLean M.D.			
PHYSICIAN'S NAME (Type) Dr. James E. McLean Cumberland, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 28, 1958	
22c. NAME OF CEMETERY OR CREMATORY Prosperity Meth Cemetery		22d. LOCATION (City, town, or county) (State) Beans Cove Road, Alleg. Co	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR DATE MAY 1 '58	
24b. REGISTRAR'S SIGNATURE W. Beach		Md.	

U.S. DEPARTMENT OF HEALTH - BIRMINGHAM 12

CERTIFICATE OF DEATH

Name of Deceased Maryland		Age 7/31/37		Sex Male		Race White		Date of Death 3/18/1937		Place of Death Maryland	
Cause of Death Coronary Thrombosis		Manner of Death Natural		Occupation None		Residence None		Hospital None		Physician None	
Signature of Physician None		Signature of Registrar None		Signature of Informant None		Signature of Coroner None		Signature of Medical Examiner None		Signature of Burial Officer None	
Name of Informant None		Address of Informant None		City of Informant None		State of Informant None		Country of Informant None		Date of Informant None	
Name of Coroner None		Address of Coroner None		City of Coroner None		State of Coroner None		Country of Coroner None		Date of Coroner None	
Name of Medical Examiner None		Address of Medical Examiner None		City of Medical Examiner None		State of Medical Examiner None		Country of Medical Examiner None		Date of Medical Examiner None	
Name of Burial Officer None		Address of Burial Officer None		City of Burial Officer None		State of Burial Officer None		Country of Burial Officer None		Date of Burial Officer None	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

FOR STATE
HEALTH DEPT.

4056

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04054

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 1 DAY d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PA. b. COUNTY SOMERSET c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MEYERSDALE d. STREET ADDRESS Lincoln Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First ETHEL Middle C. Last MURRAY			4. DATE OF DEATH Month APRIL Day 14 Year 1958		
5. SEX FEMALE			6. COLOR OR RACE WHITE		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH JULY 25-1895		
9. AGE (In years last birthday) 62 yrs.			10. FUNDING YEAR Months Days Hours Min.		
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			12. KIND OF BUSINESS OR INDUSTRY MEYERSDALE, PA.		
13. FATHER'S NAME HARDING, HERBERT			14. MOTHER'S MAIDEN NAME SHULTZ, AMANDA		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. No.		
17. INFORMANT MEMORIAL HOSPITAL-MEMORIAL & WARWICK AVES.			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO CORONARY SCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY SCLEROSIS DUE TO (c) CORONARY SCLEROSIS		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH SUDDEN ABOUT 1 YR.		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE H. V. Deming M.D.			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) DR. H. V. DEMING			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED APRIL 15, 1958		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF Apr. 18 1958		
22c. NAME OF CEMETERY OR CREMATORY Union Ceme			22d. LOCATION (City, town, or county) (State) Meyersdale Pa.		
23. FUNERAL DIRECTOR'S SIGNATURE William Horn Price			24a. REC'D BY REGISTRAR APR 22 '58		
ADDRESS Meyersdale Pa.			24b. REGISTRAR'S SIGNATURE W. H. Leach		

STATE OF MARYLAND
DEPT. OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Handwritten signature

RECEIVED
APR 22 1933
BUREAU V. S.

Handwritten signature
J. H. [illegible]
J. H. [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 04055

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY

Allegany

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE b. COUNTY

Md

Allegany

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural Cumberland Rt. # 1

c. LENGTH OF STAY IN 1b

5 yrs

x c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural- Cumberland Rt. # 1

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Bowmans Addition

d. STREET ADDRESS

Bowmans Addition

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

First Gleg

Middle Foster

Last Nelson

4. DATE OF DEATH

Month April

Day 18

Year 19 58

5. SEX

Male

6. COLOR OR RACE

white

7. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

March 18-1915

9. AGE (In years last birthday)

43 yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10b. KIND OF BUSINESS OR INDUSTRY

Celanese Corp.

11. BIRTHPLACE (State or foreign country)

Petersburg, W.Va.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James E. Nelson

14. MOTHER'S MAIDEN NAME

Provie Turner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

Yes

W.W.2

16. SOCIAL SECURITY NO.

214-07-2223

17. INFORMANT

Mrs. Rosie Mongold 150 Polk St., Cumberland, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

Cerebral hemorrhage (apoplexy)

INTERVAL BETWEEN ONSET AND DEATH

sudden

331x DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.

19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐. Inspection ☒. Inquiry ☒. and in my opinion death resulted from: Natural causes ☒. Accident ☐. Suicide ☐. Homicide ☐. Undetermined manner ☐

ACTUAL SIGNATURE

H.V. Deming M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ASSISTANT MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type)

H.V. Deming M.D.

DEPUTY MEDICAL EXAMINER ☒ April 20-1958

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

4/22/58

22c. NAME OF CEMETERY OR CREMATORY

Davis Memorial Burial Pk.

22d. LOCATION (City, town, or county)

Cumberland, Maryland

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

H. Wayne George Cumberland, Md.

24a. REC'D BY REGISTRAR

DATE

24b. REGISTRAR'S SIGNATURE

APR 24 58

W. H. Smith

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death.

BUREAU V. S.

APR 24 1958

RECEIVED

4089

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG			c. LENGTH OF STAY IN 1b X Midland		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First ISABELLE Middle B. Last NOEL			4. DATE OF DEATH Month 4 Day 17 Year 1958		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/5/1883		9. AGE (In years last birthday) 75 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Barton, MD.	
13. FATHER'S NAME George Reid		14. MOTHER'S MAIDEN NAME Agnes Garner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. CARL EWALD, Mt. SAVAGE, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Anterior-lateral Infarct Cardiac muscle DUE TO (c) 10 days					INTERVAL BETWEEN ONSET AND DEATH 2 hrs -
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 1, 1958 to April 17, 1958 , that I last saw the deceased alive on April 17, 1958 , and that death occurred at 11:00 M, from the causes and on the date stated above.					
ACTUAL SIGNATURE John B. Davis, M.D.		ADDRESS (Street, city or town, state) 2 B Roadway Frostburg, Md.			
PHYSICIAN'S NAME (Type) John B. Davis, MD		DATE SIGNED Frostburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/20/1958	22c. NAME OF CEMETERY OR CREMATORY Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHORN, LONACONING, MD.			24a. REC'D BY REGISTRAR DATE APR 21 '58		24b. REGISTRAR'S SIGNATURE Alfred Leach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

APR 21 1959

RECEIVED

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4057 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

04057

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	c. LENGTH OF STAY IN 1b 35yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 437 Waverly Terrace		d. STREET ADDRESS 437 Waverly Terrace	
3. NAME OF DECEASED (Type or print) First Nina Middle Pearl Last Parsons		4. DATE OF DEATH Month April Day 11 Year 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 1-1896
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
11. BIRTHPLACE (State or foreign country) Crabottom, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Amelia Winer		14. MOTHER'S MAIDEN NAME Susan Palmer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. None	
17. INFORMANT (husband) Emil Parsons, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 422.2 DUE TO Chronic myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic myocarditis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Gradual about 7 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE H.V. Deming M.D.		DATE SIGNED	
EXAMINER'S NAME (Type) H.V. Deming M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> April 11-1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-14-58	
22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR APR 14 58		24b. REGISTRAR'S SIGNATURE W. J. Smith	

FOR STATE
HEALTH DEPT.

MISSISSIPPI STATE DEPARTMENT OF HEALTH - BIRMINGHAM 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH		11. CAUSE OF DEATH		12. MANNER OF DEATH		13. SIGNATURE OF EXAMINER		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF CORONER		16. SIGNATURE OF JURY		17. SIGNATURE OF JUDGE		18. SIGNATURE OF CLERK		19. SIGNATURE OF SHERIFF		20. SIGNATURE OF DISTRICT ATTORNEY		21. SIGNATURE OF COUNTY CLERK		22. SIGNATURE OF TOWNSHIP CLERK		23. SIGNATURE OF VOTING CLERK		24. SIGNATURE OF POLL CLERK		25. SIGNATURE OF BALLOT CLERK		26. SIGNATURE OF CANVASSER		27. SIGNATURE OF CHIEF CLERK		28. SIGNATURE OF ASSISTANT CLERK		29. SIGNATURE OF READING CLERK		30. SIGNATURE OF RECORDING CLERK		31. SIGNATURE OF INDEXING CLERK		32. SIGNATURE OF FILING CLERK		33. SIGNATURE OF DISTRIBUTION CLERK		34. SIGNATURE OF RETURN CLERK		35. SIGNATURE OF COLLECTION CLERK		36. SIGNATURE OF DISBURSEMENT CLERK		37. SIGNATURE OF AUDIT CLERK		38. SIGNATURE OF COMPTROLLER		39. SIGNATURE OF TREASURER		40. SIGNATURE OF CLERK OF THE COURT		41. SIGNATURE OF CLERK OF THE HOUSE		42. SIGNATURE OF CLERK OF THE SENATE		43. SIGNATURE OF CLERK OF THE COMMISSION		44. SIGNATURE OF CLERK OF THE BOARD		45. SIGNATURE OF CLERK OF THE OFFICE		46. SIGNATURE OF CLERK OF THE DEPARTMENT		47. SIGNATURE OF CLERK OF THE STATE		48. SIGNATURE OF CLERK OF THE NATION		49. SIGNATURE OF CLERK OF THE WORLD		50. SIGNATURE OF CLERK OF THE UNIVERSE	
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BUREAU V. S.

APR 14 1953

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4⁵⁸ MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04058

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 22 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 420 Independence St.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
3. NAME OF DECEASED (Type or print) Augusta XXXXXX May Paxton		4. DATE OF DEATH April 9 19 58	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 3- 1893
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Hartford, Conn.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Julius Hallier		14. MOTHER'S MAIDEN NAME Alice Nues	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT (daughter) Alice Wertz, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerosis with hypertention [a], stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH sudden several years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE H.V. Deming M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H.V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED April 9-1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/12/58	
22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hager		24a. REC'D BY REGISTRAR DATE APR 14 1958	
24b. REGISTRAR'S SIGNATURE W. J. ...			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 22
1938 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		45		M		W		1938		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF BURIAL		DATE OF BURIAL	
1234 E. BALTIMORE ST.		Carpenter		Heart Disease		Natural		St. Mary's Cemetery		1938	
DATE OF EXAMINATION		BY EXAMINER		FINDINGS		REMARKS		SIGNATURE		TITLE	
1938		J. H. HARRIS		No signs of violence or disease		No signs of disease		J. H. HARRIS		Medical Examiner	
DATE OF EXAMINATION		BY EXAMINER		FINDINGS		REMARKS		SIGNATURE		TITLE	
1938		J. H. HARRIS		No signs of violence or disease		No signs of disease		J. H. HARRIS		Medical Examiner	

RECEIVED
APR 14 1938
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death.

VS. A15ME
SM 2/57

FOR STATE
HEALTH-DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4059 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 04059

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) A. at-Memorial Hospital		d. STREET ADDRESS / 1 10 N.Ceder St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mitchell Middle T. Last Payne		4. DATE OF DEATH Month April Day 28 Year 19 58	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec.161957
9. AGE (In years last birthday) 0 yrs.		IF UNDER 1 YEAR Months 4 Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Cumberland, Md.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Riley Payne		14. MOTHER'S MAIDEN NAME Margaret C.Priddey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT (mother) Margaret C. Payne, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation 9210 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Pulmonary edema and (c) Laryngospasum		INTERVAL BETWEEN ONSET AND DEATH sudden ? sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) stomach contents.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. Presume baby rolled over on abdomen, then aspiration of		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) stomach contents.	
20c. TIME OF INJURY Month, Day, Year 12-10-1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) In a home		20f. (City or town) (County) (State) Cumberland, Allegany, Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE H.V. Deming M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H.V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED April 28-1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-30-58	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli Cumberland, Md.		24a. REC'D BY REGISTRAR DATE MAY 2 '58	
24b. REGISTRAR'S SIGNATURE W. H. Leach			

2060191XV6



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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for patient information, medical history, and examiner's signature.

1. PATIENT'S NAME: _____

2. SEX: ☐ Male ☐ Female

3. AGE: _____

4. DATE OF BIRTH: _____

5. PLACE OF BIRTH: _____

6. OCCUPATION: _____

7. PRESENT ILLNESS: _____

8. HISTORY OF PRESENT ILLNESS: _____

9. PREVIOUS ILLNESSES: _____

10. MEDICAL HISTORY: _____

11. PHYSICAL EXAMINATION: _____

12. LABORATORY EXAMINATIONS: _____

13. RADIOLOGIC EXAMINATIONS: _____

14. PATHOLOGIC EXAMINATIONS: _____

15. CAUSE OF DEATH: _____

16. MANNER OF DEATH: _____

17. SIGNATURE OF MEDICAL EXAMINER: _____

18. DATE: _____

19. PLACE: _____

20. COUNTY: _____

21. STATE: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4660

CERTIFICATE OF DEATH

04060

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY -ALLEGANY							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 29		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KITZMILLER 11X-2 ✓					
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MIDDLE Last NELLIE PEARL PERANDO				4. DATE OF DEATH Month Day Year APRIL 21 1958							
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 21		9. AGE (In years last birthday) yrs. 62		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U. S. OF AMERICA	
13. FATHER'S NAME GEORGE LOUGHRY				14. MOTHER'S MAIDEN NAME IDA MAY WRIGHT							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. ---		17. INFORMANT Address MEMORIAL HOSPITAL CUMBERLAND, MD.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 252.0 probable coronary DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) secondary to hyperthyroid - post operative PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Mar 23, 1958, to April 21, 1958, that I last saw the deceased alive on April 21, 1958, and that death occurred at 5:15 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE David H Miller M.D. 22 Washington St. PHYSICIAN'S NAME (Type) DR. DAVID MILLER Cumberland Md.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 4/24/58				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Tierra Alta-Cem.		22d. LOCATION (City, town, or county) (State) Tierra Alta, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE H. C. Reighton - Oakland, Md.				ADDRESS		24a. REC'D BY REGISTRAR DATE APR 23 '58		24b. REGISTRAR'S SIGNATURE W. J. ...			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4061

CERTIFICATE OF DEATH

04061

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE W. Va. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 9 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Granville Middle Roscoe Last Poland				4. DATE OF DEATH Month 4/14 Day 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/2/88	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Fireman				10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Hampshire W. Va. - County	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Gerald Poland				14. MOTHER'S MAIDEN NAME Harriett Lewis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. Pt's chart		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis with Coronary disease 5 years DUE TO (c) 12 hours PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Branches of Arteries 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-13 , 19 58 , to 4-14 , 19 58 , that I last saw the deceased alive on 4-13 , 19 58 , and that death occurred at 12:30 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 16 Queen St Cumberland Md 4-1558 DATE SIGNED 4-15-58 ACTUAL SIGNATURE J. V. Johnson Jr M.D. PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-16-58		22c. NAME OF CEMETERY OR CREMATORY Baptist Cemetery		22d. LOCATION (City, town, or county) (State) Three Churches, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				24a. REC'D BY REGISTRAR DATE APR 17 '58		24b. REGISTRAR'S SIGNATURE Al Lewis	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH-BALTIMORE 12
CERTIFICATE OF DEATH

RECEIVED
APR 17 1958
BURLAU M.F.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4990

Item 14 Film 3228 5-12-58 et

CERTIFICATE OF DEATH

Reg. Dist. No.

04062

1. PLACE OF DEATH a. COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Zihlman R. D. No 2, Frostburg	
c. LENGTH OF STAY IN 1b 3 wks.		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miner's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Benjamin Middle Franklin Last Porter		4. DATE OF DEATH Month 4 Day 30 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-10-1878
9. AGE (In years last birthday) 79 rs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Zihlman		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Porter		14. MOTHER'S MAIDEN NAME Emma Burton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 213-09-6471	
17. INFORMANT R. D. No. 2, Box 129 Frostburg, Md.		Address Mrs. Raymond Anderson, Grand Daughter	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CIRRHOSIS OF LIVER 581.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 10 YEARS		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 1958 , to April 1958 , that I last saw the deceased alive on April 29, 1958 , and that death occurred at 2 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John C. Devers M.D.		ADDRESS (Street, city or town, state) 134 E Main DATE SIGNED 5/6/58	
PHYSICIAN'S NAME (Type) John C. Devers		Frostburg, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-2-1958	22c. NAME OF CEMETERY OR CREMATORY Porter Cemetery	22d. LOCATION (City, town, or county) (State) Eckhart Md.
23. FUNERAL DIRECTOR'S SIGNATURE B. H. Mattingly ADDRESS Hafer Funeral Home Frostburg, Md.		24a. REC'D BY REGISTRAR DATE MAY 5 '58 24b. REGISTRAR'S SIGNATURE W. Beach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

462

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MINERAL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 1 DAY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS RT.#1	
3. NAME OF DECEASED (Type or print) First FLOYD Middle D. Last POWELL		4. DATE OF DEATH Month APRIL Day 25 Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-28-1889
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BOILER ROOM		10b. KIND OF BUSINESS OR INDUSTRY ALLEGANY BALLISTICS	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WALTER POWELL		14. MOTHER'S MAIDEN NAME MARY ALENDER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-10-7216	
17. INFORMANT Mrs. Mary E. Powell		Address Rt.1 Ridgeley, W. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 1 week 1 year
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 4-6 , 19 58 , to 4-25 , 19 58 , that I last saw the deceased alive on 4-25 , 19 58 , and that death occurred at 1:40 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 62 Greene St. Cumberland, Md. DATE SIGNED 4-26-58			
ACTUAL SIGNATURE Dr. R. Ballin		M.D. 62 Greene St. Cumberland, Md.	
PHYSICIAN'S NAME (Type) DR. R. BALLIN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-28-1958	22c. NAME OF CEMETERY OR CREMATORY Genevan Cemetery	22d. LOCATION (City, town, or county) (State) Neals Run, W. Va.
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR APR 30 1958		24b. REGISTRAR'S SIGNATURE Quinn	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1965

1. PLACE OF DEATH a. HOME		2. SEX a. MALE	
b. OTHER		c. RACE	
3. DATE OF DEATH a. MONTH		b. DAY	
c. YEAR		4. TIME OF DEATH	
5. PLACE OF DEATH a. HOME		b. OTHER	
6. CAUSE OF DEATH a. DISEASE		b. INJURY	
c. OTHER		7. MANNER OF DEATH	
8. PLACE OF DEATH a. HOME		b. OTHER	
9. PLACE OF DEATH a. HOME		b. OTHER	
10. PLACE OF DEATH a. HOME		b. OTHER	
11. PLACE OF DEATH a. HOME		b. OTHER	
12. PLACE OF DEATH a. HOME		b. OTHER	
13. PLACE OF DEATH a. HOME		b. OTHER	
14. PLACE OF DEATH a. HOME		b. OTHER	
15. PLACE OF DEATH a. HOME		b. OTHER	
16. PLACE OF DEATH a. HOME		b. OTHER	
17. PLACE OF DEATH a. HOME		b. OTHER	
18. PLACE OF DEATH a. HOME		b. OTHER	
19. PLACE OF DEATH a. HOME		b. OTHER	
20. PLACE OF DEATH a. HOME		b. OTHER	
21. PLACE OF DEATH a. HOME		b. OTHER	
22. PLACE OF DEATH a. HOME		b. OTHER	
23. PLACE OF DEATH a. HOME		b. OTHER	
24. PLACE OF DEATH a. HOME		b. OTHER	
25. PLACE OF DEATH a. HOME		b. OTHER	
26. PLACE OF DEATH a. HOME		b. OTHER	
27. PLACE OF DEATH a. HOME		b. OTHER	
28. PLACE OF DEATH a. HOME		b. OTHER	
29. PLACE OF DEATH a. HOME		b. OTHER	
30. PLACE OF DEATH a. HOME		b. OTHER	
31. PLACE OF DEATH a. HOME		b. OTHER	
32. PLACE OF DEATH a. HOME		b. OTHER	
33. PLACE OF DEATH a. HOME		b. OTHER	
34. PLACE OF DEATH a. HOME		b. OTHER	
35. PLACE OF DEATH a. HOME		b. OTHER	
36. PLACE OF DEATH a. HOME		b. OTHER	
37. PLACE OF DEATH a. HOME		b. OTHER	
38. PLACE OF DEATH a. HOME		b. OTHER	
39. PLACE OF DEATH a. HOME		b. OTHER	
40. PLACE OF DEATH a. HOME		b. OTHER	
41. PLACE OF DEATH a. HOME		b. OTHER	
42. PLACE OF DEATH a. HOME		b. OTHER	
43. PLACE OF DEATH a. HOME		b. OTHER	
44. PLACE OF DEATH a. HOME		b. OTHER	
45. PLACE OF DEATH a. HOME		b. OTHER	
46. PLACE OF DEATH a. HOME		b. OTHER	
47. PLACE OF DEATH a. HOME		b. OTHER	
48. PLACE OF DEATH a. HOME		b. OTHER	
49. PLACE OF DEATH a. HOME		b. OTHER	
50. PLACE OF DEATH a. HOME		b. OTHER	
51. PLACE OF DEATH a. HOME		b. OTHER	
52. PLACE OF DEATH a. HOME		b. OTHER	
53. PLACE OF DEATH a. HOME		b. OTHER	
54. PLACE OF DEATH a. HOME		b. OTHER	
55. PLACE OF DEATH a. HOME		b. OTHER	
56. PLACE OF DEATH a. HOME		b. OTHER	
57. PLACE OF DEATH a. HOME		b. OTHER	
58. PLACE OF DEATH a. HOME		b. OTHER	
59. PLACE OF DEATH a. HOME		b. OTHER	
60. PLACE OF DEATH a. HOME		b. OTHER	
61. PLACE OF DEATH a. HOME		b. OTHER	
62. PLACE OF DEATH a. HOME		b. OTHER	
63. PLACE OF DEATH a. HOME		b. OTHER	
64. PLACE OF DEATH a. HOME		b. OTHER	
65. PLACE OF DEATH a. HOME		b. OTHER	
66. PLACE OF DEATH a. HOME		b. OTHER	
67. PLACE OF DEATH a. HOME		b. OTHER	
68. PLACE OF DEATH a. HOME		b. OTHER	
69. PLACE OF DEATH a. HOME		b. OTHER	
70. PLACE OF DEATH a. HOME		b. OTHER	
71. PLACE OF DEATH a. HOME		b. OTHER	
72. PLACE OF DEATH a. HOME		b. OTHER	
73. PLACE OF DEATH a. HOME		b. OTHER	
74. PLACE OF DEATH a. HOME		b. OTHER	
75. PLACE OF DEATH a. HOME		b. OTHER	
76. PLACE OF DEATH a. HOME		b. OTHER	
77. PLACE OF DEATH a. HOME		b. OTHER	
78. PLACE OF DEATH a. HOME		b. OTHER	
79. PLACE OF DEATH a. HOME		b. OTHER	
80. PLACE OF DEATH a. HOME		b. OTHER	
81. PLACE OF DEATH a. HOME		b. OTHER	
82. PLACE OF DEATH a. HOME		b. OTHER	
83. PLACE OF DEATH a. HOME		b. OTHER	
84. PLACE OF DEATH a. HOME		b. OTHER	
85. PLACE OF DEATH a. HOME		b. OTHER	
86. PLACE OF DEATH a. HOME		b. OTHER	
87. PLACE OF DEATH a. HOME		b. OTHER	
88. PLACE OF DEATH a. HOME		b. OTHER	
89. PLACE OF DEATH a. HOME		b. OTHER	
90. PLACE OF DEATH a. HOME		b. OTHER	
91. PLACE OF DEATH a. HOME		b. OTHER	
92. PLACE OF DEATH a. HOME		b. OTHER	
93. PLACE OF DEATH a. HOME		b. OTHER	
94. PLACE OF DEATH a. HOME		b. OTHER	
95. PLACE OF DEATH a. HOME		b. OTHER	
96. PLACE OF DEATH a. HOME		b. OTHER	
97. PLACE OF DEATH a. HOME		b. OTHER	
98. PLACE OF DEATH a. HOME		b. OTHER	
99. PLACE OF DEATH a. HOME		b. OTHER	
100. PLACE OF DEATH a. HOME		b. OTHER	

BUREAU V. 2

APR 30 1968

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

463

Item 9 Film G227 4-11-58 et

CERTIFICATE OF DEATH

Reg. Dist. No. 04064

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY HAMPSHIRE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROMNEY 85X-3 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS 456 GRAVEL LANE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First PEARL Middle H. Last PUE		4. DATE OF DEATH Month APRIL Day 3 Year 19 58	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 11, 1882
9. AGE (In years last birthday) 75 7/8 yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) THREE CHURCHES, W.VA.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JAMES THOMPSON		14. MOTHER'S MAIDEN NAME ELIZABETH PARKER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio sclerotic Cardia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) vascular disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 14, 1938 , to 4-3-1958 , that I last saw the deceased alive on 4-3-1958 , and that death occurred at 11:50P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE W. F. Williams M.D.		ADDRESS (Street, city or town, state) Cumberland Md DATE SIGNED 4-4-58	
PHYSICIAN'S NAME (Type) DR. W.F. WILLIAMS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 6	
22c. NAME OF CEMETERY OR CREMATORY Indian Mound		22d. LOCATION (City, town, or county) (State) Romney W.Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Keith Shaffer		ADDRESS Romney W.Va.	
24a. REC'D BY REGISTRAR APR 9 '58		24b. REGISTRAR'S SIGNATURE W. K. Z.	

STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

APR 9 1958

RECEIVED

TO BURIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4064

CERTIFICATE OF DEATH

04065

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegheny</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>Ind</u> b. COUNTY <u>Allegheny</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>		d. STREET ADDRESS <u>Willowbrook Rd.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Willowbrook Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Calvin</u> Last <u>Reager</u>				4. DATE OF DEATH Month <u>Apr</u> Day <u>2</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Sept 12, 1879</u>	9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B+O Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Warrenton Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S</u>	
13. FATHER'S NAME <u>Harry Reager</u>				14. MOTHER'S MAIDEN NAME <u>Mary Louise Payne</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>701</u>		17. INFORMANT <u>Jona Randalls - Elm St - Cumberland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Short Fracture</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio-Vascular Disease</u> DUE TO (c) <u>2 years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>20 January 1958</u> , to <u>2 April, 1958</u> , that I last saw the deceased alive on <u>1 April</u> , 1958, and that death occurred at <u>5 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James G. Stegmaier</u>				ADDRESS (Street, city or town, state) <u>M.D. 122 So Centre St. Cumberland Md.</u>			
PHYSICIAN'S NAME (Type) <u>James G. Stegmaier</u>				DATE SIGNED <u>3 April 58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Cremation</u>		<u>4/4/58</u>		<u>Cedar Hill Crematory</u>		<u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Hofer Cumberland Ind</u>				24a. REC'D BY REGISTRAR <u>APR 7 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Smith</u>	

CERTIFICATE OF DEATH

BURMAN V. S.

APR 7 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

465

CERTIFICATE OF DEATH

Reg. Dist. No.

04066

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 13 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FRANCES Middle PEARL Last REITER				4. DATE OF DEATH Month APRIL Day 26 Year 1958			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 9, 1891	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months 6 Days 26 Hours 19 Min. 58		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY School Teacher	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA, Leysburg				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME NATHANIEL REPLOGLE				14. MOTHER'S MAIDEN NAME ALICE MARKEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-36-8598		17. INFORMANT MEMORIAL HOSPITAL Address CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma left breast 170X DUE TO (b) Carcinomatosis Abdominal DUE TO (c) viscera Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Dermatomyositis						INTERVAL BETWEEN ONSET AND DEATH Sept '56	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12.12.1957 to 4.26.1958 , that I last saw the deceased alive on 4.26.1958 , and that death occurred at 4:50P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Mr. F. Williams M.D.				ADDRESS (Street, city or town, state) Cumberland Md.			
DATE SIGNED 4-28-58							
PHYSICIAN'S NAME (Type) DR. WILLIAM F. WILLIAMS							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Apr. 29, 1958		22c. NAME OF CEMETERY OR CREMATORY Sunset Mem. Park		22d. LOCATION (City, town, or county) (State) Cumberland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hoyer, Cumberland, Md.				24a. REC'D BY REGISTRAR DATE MAY 1 '58		24b. REGISTRAR'S SIGNATURE Rebecca	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4066

CERTIFICATE OF DEATH

Reg. Dist. No.

04067

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 54 Oak Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Carl Middle George Last Reuschel		4. DATE OF DEATH Month April Day 8 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 30, 1901
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carman		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Reuschel		14. MOTHER'S MAIDEN NAME Louise Moot	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 705-12-0870	
17. INFORMANT Mrs. Barbara Murphy, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Coronary Arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH Immediate 5 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 4/10/58 , 19____, to 4/8/58 , 19____, that I last saw the deceased alive on 4/2/58 , 19____, and that death occurred at 7 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE Richard J. Williams M.D.		DATE SIGNED April 8, 1958	
PHYSICIAN'S NAME (Type) Richard J. Williams M.D.		Cumberland, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Apr. 11, 1958	22c. NAME OF CEMETERY OR CREMATORY St. Luke's Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		24a. REC'D BY REGISTRAR DATE APR 14 '58	
24b. REGISTRAR'S SIGNATURE W. H. H. H.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 of 2. Page 2 of 2. Page 3 of 2. Page 4 of 2. Page 5 of 2. Page 6 of 2. Page 7 of 2. Page 8 of 2. Page 9 of 2. Page 10 of 2. Page 11 of 2. Page 12 of 2. Page 13 of 2. Page 14 of 2. Page 15 of 2. Page 16 of 2. Page 17 of 2. Page 18 of 2. Page 19 of 2. Page 20 of 2. Page 21 of 2. Page 22 of 2. Page 23 of 2. Page 24 of 2. Page 25 of 2. Page 26 of 2. Page 27 of 2. Page 28 of 2. Page 29 of 2. Page 30 of 2. Page 31 of 2. Page 32 of 2. Page 33 of 2. Page 34 of 2. Page 35 of 2. Page 36 of 2. Page 37 of 2. Page 38 of 2. Page 39 of 2. Page 40 of 2. Page 41 of 2. Page 42 of 2. Page 43 of 2. Page 44 of 2. Page 45 of 2. Page 46 of 2. Page 47 of 2. Page 48 of 2. Page 49 of 2. Page 50 of 2. Page 51 of 2. Page 52 of 2. Page 53 of 2. Page 54 of 2. Page 55 of 2. Page 56 of 2. Page 57 of 2. Page 58 of 2. Page 59 of 2. Page 60 of 2. Page 61 of 2. Page 62 of 2. Page 63 of 2. 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RECEIVED

4091

CERTIFICATE OF DEATH

Reg. Dist. No.

04068

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN lb 12 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miner's Hospital				d. STREET ADDRESS 163 Center Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lillian Folk Richardson				4. DATE OF DEATH Month Day Year April 25th, 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 18th, 1887	
9. AGE (In years last birthday) yrs. 70		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Housework		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Charles W. Folk				14. MOTHER'S MAIDEN NAME Elizabeth Eisel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-09-6498B		17. INFORMANT Address Earl Richardson, Frostburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Peritonitis 561.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Incarcerated femoral hernia (RT) DUE TO (c) Perforation small bowel (ileum) INTERVAL BETWEEN ONSET AND DEATH 3-4 days 2 1/2 wks 3-4 days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-10 , 19 58 , to 4-25 , 19 58 , that I last saw the deceased alive on 4-25 , 19 58 , and that death occurred at 4:50 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 39 W. Main St., Frostburg, Md. DATE SIGNED 4/25/58 ACTUAL SIGNATURE H.C. Dietrich PHYSICIAN'S NAME (Type) H.C. Dietrich M.D., Frostburg, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-27-58		22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst, Frostburg, Md.				24a. REC'D BY REGISTRAR APR 28 1958		24b. REGISTRAR'S SIGNATURE Deborah	

VS A15 (4)
15M 10/57

VS A1S (4)
15M 10/57

CERTIFICATE OF DEATH

BUREAU V. S.

APR 28 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item #9 - Film G227 - 4/10/58-mb

CERTIFICATE OF DEATH

04069

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	c. LENGTH OF STAY IN 1b 5 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. STREET ADDRESS 320 ARCH STREET	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First EMMA Middle VICTORIA Last RICKENBERG		4. DATE OF DEATH Month APRIL Day 3 Year 19 58	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 27, 1883
9. AGE (In years last birthday) 74 1/2		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) WEST VIRGINIA
13. FATHER'S NAME RICHARD STOTT		14. MOTHER'S MAIDEN NAME ANNA PETRY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic cardiac vas. 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) diagnose DUE TO (c) 1948 INTERVAL BETWEEN ONSET AND DEATH None			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 8-31-1957 to 4-3-1958 , that I last saw the deceased alive on 4-2-1958 , and that death occurred at 3:40 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE W. F. Williams		ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED	
PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/5/58	22c. NAME OF CEMETERY OR CREMATORY Green Hill Cem.	22d. LOCATION (City, town, or county) (State) Martinsburg W. Va.
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer		24a. REC'D BY REGISTRAR APR 7 '58	
ADDRESS Cumberland Md		24b. REGISTRAR'S SIGNATURE Deborah	

CERTIFICATE OF DEATH

Form No. 10

1. Name of deceased: *John Doe*

2. Sex: *Male*

3. Date of birth: *Jan 1, 1900*

4. Place of birth: *Johns Hopkins*

5. Date of death: *Dec 1, 1958*

6. Place of death: *Johns Hopkins*

7. Cause of death: *Heart Disease*

8. Manner of death: *Natural*

9. Signature of physician: *John Doe*

10. Signature of registrar: *John Doe*

11. Signature of coroner: *John Doe*

12. Signature of medical examiner: *John Doe*

13. Signature of funeral director: *John Doe*

14. Signature of undertaker: *John Doe*

15. Signature of cemetery: *John Doe*

16. Signature of burial place: *John Doe*

17. Signature of interment: *John Doe*

18. Signature of final disposition: *John Doe*

19. Signature of final disposition: *John Doe*

20. Signature of final disposition: *John Doe*

21. Signature of final disposition: *John Doe*

22. Signature of final disposition: *John Doe*

23. Signature of final disposition: *John Doe*

24. Signature of final disposition: *John Doe*

25. Signature of final disposition: *John Doe*

26. Signature of final disposition: *John Doe*

27. Signature of final disposition: *John Doe*

28. Signature of final disposition: *John Doe*

29. Signature of final disposition: *John Doe*

30. Signature of final disposition: *John Doe*

31. Signature of final disposition: *John Doe*

32. Signature of final disposition: *John Doe*

BUREAU V. 3

APR 7 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

468

CERTIFICATE OF DEATH

04070

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY HAMPSHIRE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 32 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NOAH Middle MILES Last RIGGLEMAN		4. DATE OF DEATH Month APRIL Day 23 Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-19-1887
9. AGE (In years last birthday) yrs. 70		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MINER		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) KEYSER, W. VA.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME NOAH RIGGLEMAN		14. MOTHER'S MAIDEN NAME ANGELINE ROHRBAUGH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 236-01-8940	
17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) aplastic Bone marrow 722.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatoid arthritis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 months 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 1954 , to 23 Apr. 1958 , that I last saw the deceased alive on 27 Apr. 1958 , and that death occurred at 4:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Alfred Van Ormer M.D.		ADDRESS (Street, city or town, state) 1225 Centre St. Cumberland, Md.	
DATE SIGNED 23 Apr. 58			
PHYSICIAN'S NAME (Type) DR. W. A. VAN ORMER			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/27/58	
22c. NAME OF CEMETERY OR CREMATORY Indian Mound Cemetery Romney		22d. LOCATION (City, town, or county) (State) W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox		ADDRESS Cumberland, Maryland	
24a. REC'D BY REGISTRAR APR 25 '58		24b. REGISTRAR'S SIGNATURE Alfred Smith	

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

. MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

04071

FOR STATE
HEALTH DEPT.

4-69

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	c. LENGTH OF STAY IN 1b 1 mo.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 174 Baltimore St.		d. STREET ADDRESS 174 Baltimore St.	
3. NAME OF DECEASED (Type or print) Otha Rollin Roderick		4. DATE OF DEATH April 30 19 58	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 20-1906
9. AGE (In years, months, days) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engineer to the U.S.G.		10b. NAME OF BUSINESS OR INDUSTRY Camp Detrick, Md.	
11. BIRTHPLACE (State or foreign country) Hartmansville, W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ephrim Roderick		14. MOTHER'S MAIDEN NAME Tolia Fout	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 235-18-1178	
17. INFORMANT (brother) Lawrence Roderick, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO (b) Coronary sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Arteriosclerosis with hypertention INTERVAL BETWEEN ONSET AND DEATH sudden ? About 4 years.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE H.V. Deming M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H.V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> May 1-1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 3, 1958	22c. NAME OF CEMETERY OR CREMATORY Kalbaugh Cemetery	22d. LOCATION (City, town, or county) (State) Elk Garden, W. Va.
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight Cumberland, Md.		24b. REGISTRAR'S SIGNATURE Alfred	
24a. REC'D BY REGISTRAR MAY 5 '58		DATE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

STATE OF CALIFORNIA

ATTN:
HEALTH DEPT

RECEIVED
JAN 10 1950

DATE: JAN 10 1950

REPORT NO. 100-100000

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

NAME OF DECEASED

DATE OF DEATH

AGE

SEX

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

OCCUPATION

RELIGION

ETHNIC ORIGIN

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

PREVIOUS OTHER

PREVIOUS UNKNOWN

1
M
60
I
0
1
VS A15 (4)
15M 9/55

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04072

4070

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 9 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First C. Middle EDWARD Last SCHLUND		4. DATE OF DEATH Month APRIL Day 11 Year 19 58	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28, 1878 OCTOBER 1878
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED - Greenhouse florist		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JOHN C. SCHLUND		14. MOTHER'S MAIDEN NAME MARY GOOR	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) Chronic Myocarditis 10 yrs		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/7/48, 19, to 4/11/58, 19, that I last saw the deceased alive on 4/11/58, 19, and that death occurred at 10:40 P. M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE DR. R.J. WILLIAMS		DATE SIGNED 4/12/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/14/58	
22c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox		ADDRESS Cumberland, Maryland	
24a. REC'D BY REGISTRAR DATE APR 16 1958		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		M		W		1893		BALTIMORE, MARYLAND	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL ATTENDANT	
APR 15 1968		BALTIMORE, MARYLAND		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		DR. J. H. HARRIS	
TIME OF DEATH		HOURS		MINUTES		P.M.		TEMPERATURE		PULSE	
10:00		10		00		P.M.		98.6		60	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF MEDICAL ATTENDANT		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF JUDGE	
				J. H. HARRIS							
DATE OF FILING		PLACE OF FILING		FILING OFFICE		FILING NUMBER		FILING DATE		FILING TIME	
APR 16 1968		BALTIMORE, MARYLAND		HEALTH DEPARTMENT		100-100000		APR 16 1968		10:00	

BUREAU W. H.

APR 16 1968

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4071

CERTIFICATE OF DEATH

Reg. Dist. No.

04073

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 65 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL WARWICK & MEMORIAL AVES.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ROBERT Middle DEMPSEY Last SECRIST				4. DATE OF DEATH Month APRIL Day 27 Year 1958			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 23, 1900	
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Burns Cuboid Co.	
11. BIRTHPLACE (State or foreign country) BUCHANAN, VA.		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME ROBERT D. SECRIST SR.		14. MOTHER'S MAIDEN NAME Nannie Linkenbaker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 095-01-1632		17. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260x Gangrene, both legs DUE TO (b) Arteriosclerosis DUE TO (c) Diabetes Mellitus							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from 4-27 , 19 58 , to 4-27 , 19 58 , that I last saw the deceased alive on 4-27 , 19 58 , and that death occurred at 8:45 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Leo H. Ley Jr.				ADDRESS (Street, city or town, state) 452 N. Centre St. Cumberland, Md.			
DATE SIGNED 4/28/58				PHYSICIAN'S NAME (Type) DR. LEO H. LEY			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/29/58		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George ADDRESS Cumberland, Md.				24a. REC'D BY REGISTRAR MAY 1 '58		24b. REGISTRAR'S SIGNATURE Alfred Smith	

CERTIFICATE OF DEATH

Form 10-1-1

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>	
<p>3. AGE [REDACTED]</p>		<p>4. RACE [REDACTED]</p>	
<p>5. DATE OF BIRTH [REDACTED]</p>		<p>6. DATE OF DEATH [REDACTED]</p>	
<p>7. PLACE OF BIRTH [REDACTED]</p>		<p>8. PLACE OF DEATH [REDACTED]</p>	
<p>9. OCCUPATION [REDACTED]</p>		<p>10. CAUSE OF DEATH [REDACTED]</p>	
<p>11. MEDICAL HISTORY [REDACTED]</p>		<p>12. MANNER OF DEATH [REDACTED]</p>	
<p>13. SIGNATURE OF PHYSICIAN [REDACTED]</p>		<p>14. SIGNATURE OF CORONER [REDACTED]</p>	
<p>15. SIGNATURE OF WITNESS [REDACTED]</p>		<p>16. SIGNATURE OF DECEASED [REDACTED]</p>	

FILE IN COLLECTION

CERTIFICATE OF DEATH

APR 18 1959

RECEIVED

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04075

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH

a. COUNTY

Allegany

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Frostburg

c. LENGTH OF STAY IN 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Md.

b. COUNTY

Allegany

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X La Vale

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Miners Hospital

d. STREET ADDRESS

9 Richard Way, Coverwood.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

Margaret ^{First} Smith ^{Middle} MacFarlane ^{Last} Shaw

4. DATE OF DEATH

Month April Day 10 Year 19 58

5. SEX

Female

6. COLOR OR RACE

white

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

May 25-1902

9. AGE (In years last birthday) 55 yrs.

IF UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

retired laboratory technician & Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Cumberland, Md.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John B. Mac Farlane

14. MOTHER'S MAIDEN NAME

E lizabeth Grant

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

(husband) Andrew B. Shaw, LaVale, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

Exsanguination due to a 38 caliber

INTERVAL BETWEEN ONSET AND DEATH sudden

976X DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) revolver wound in chest, near left nipple

(c) region, self inflicted.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☒ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Shot herself with a 38 caliber revolver in left chest.

20c. TIME OF INJURY Hour * 7.30 p. m.

Month, Day, Year April 10 1958

20d. INJURY OCCURRED While ☐ Not while ☒ at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

Home

20f. (City or town)

LaVale Allegany

(County)

(State)

Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐. Inspection ☒. Inquiry ☒. and in my opinion death resulted from: Natural causes ☐. Accident ☐. Suicide ☒. Homicide ☐. Undetermined manner ☐

ACTUAL SIGNATURE

H. V. Deming M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

EXAMINER'S NAME (Type)

H. V. Deming M.D.

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒ April 11-1958

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

4/13/58

22c. NAME OF CEMETERY OR CREMATORY

Laurel Hill

22d. LOCATION (City, town, or county)

Moscow

(State)

Md.

23. FUNERAL DIRECTOR'S SIGNATURE

E. J. Boal

ADDRESS

Westernport, Md.

24a. REC'D BY REGISTRAR

APR 15 1958

24b. REGISTRAR'S SIGNATURE

Overhach

FOR STATE
HEALTH DEPT.

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

THIS CERTIFICATE IS TO BE FILLED OUT BY THE MEDICAL EXAMINER WHO HAS EXAMINED THE BODY OF THE DECEASED PERSON.

1. NAME OF DECEASED: _____

2. SEX: _____

3. AGE: _____

4. OCCUPATION: _____

5. PLACE OF BIRTH: _____

6. DATE OF BIRTH: _____

7. DATE OF DEATH: _____

8. TIME OF DEATH: _____

9. PLACE OF DEATH: _____

10. CAUSE OF DEATH: _____

11. MANNER OF DEATH: _____

12. SIGNATURE OF MEDICAL EXAMINER: _____

13. TITLE OF MEDICAL EXAMINER: _____

14. ADDRESS OF MEDICAL EXAMINER: _____

15. CITY: _____

16. COUNTY: _____

17. STATE: _____

18. ZIP CODE: _____

19. TELEPHONE: _____

20. FAX: _____

21. E-MAIL: _____

22. OTHER: _____

BUREAU V. 5

APR 15 1958

RECEIVED

4093

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b X Midland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				d. STREET ADDRESS /			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First William Middle Shearer Last Shearer				4. DATE OF DEATH Month April Day 6 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 10, 1889	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none			10b. KIND OF BUSINESS OR INDUSTRY Midland, Maryland		11. BIRTHPLACE (State or foreign country) U.S.A.		
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME William Shearer				
14. MOTHER'S MAIDEN NAME Elizabeth Goodrich			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				
16. SOCIAL SECURITY NO.			17. INFORMANT Mrs. Wilbert Rennie Address Lonaconing, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerotic Heart disease 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Left Ventricular Failure 2 days DUE TO (c) Diabetic Acidosis, Uremia							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 4/4 19 58 , to 4/6 19 58 , that I last saw the deceased alive on 4/5 19 58 , and that death occurred at 1055 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 124 E. Main Frostburg, Md. DATE SIGNED John C. Lucas							
ACTUAL SIGNATURE John C. Lucas M.D.							
PHYSICIAN'S NAME (Type) John C. Lucas							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/9/58		22c. NAME OF CEMETERY OR CREMATORY Vale Summit Cemetery		22d. LOCATION (City, town, or county) (State) Vale Summit, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn				24a. REC'D BY REGISTRAR APR 9 '58		24b. REGISTRAR'S SIGNATURE W. H. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 45C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

04077

4104

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Garrett</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rawlings</u>		LENGTH OF STAY (in this place) <u>3 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Deer Park</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Edward</u> (Middle) <u>Eli</u> (Last) <u>Sollars</u>				(Month) <u>April</u> (Day) <u>21</u> (Year) <u>19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Oct 6 1884</u>	9. AGE last birthday <u>73</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>M.D.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Hoyes, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Edward E. Sollars</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Keller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Edw. Eli Sollars, Jr. DeerPark, Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A) <u>Arteriosclerotic cardiovascular disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 1956</u> , to <u>April 21, 1958</u> , that I last saw the deceased alive on <u>April 21, 1958</u> , and that death occurred at <u>8:00 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James W. Funchak</u>				ADDRESS (Street, city, town, state) <u>Richmont W. Va.</u>			
DATE SIGNED <u>4-21-58</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Apr. 23/58</u>		NAME OF CEMETERY OR CREMATORY <u>DeerPark Cemetery</u>		LOCATION (City, town, or county) (State) <u>Deer Park, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>APR 28 '58</u>		REGISTRAR'S SIGNATURE <u>Alfred</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Funchak</u> ADDRESS <u>Richmont, W. Va.</u>			

CERTIFICATE OF DEATH

Reg. Dist. No.

County

Dec. 1958

Age

Sex

Marital Status

Occupation

Place of Birth

Place of Death

Place of Death

Time of Death

Cause of Death

Immediate Cause of Death

Immediate Cause of Death

Immediate Cause of Death

Signature

Signature

Witness

Physician

Physician

BUREAU V. S.

APR 29 1958

RECEIVED

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4073

CERTIFICATE OF DEATH

Reg. Dist. No. 04078

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) p. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 15 MINS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle C. Last STORER				4. DATE OF DEATH Month APRIL Day 22 Year 1958			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 2, 1904	
9. AGE (In years last birthday) 54 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOREMAN KELLY		10b. KIND OF BUSINESS OR INDUSTRY Tire Industry		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME ERNEST STORER			
14. MOTHER'S MAIDEN NAME GRACE W. SPIER				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 214-07-0863				17. INFORMANT MEMORIAL HOSPITAL Address CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 1.5 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from 2/3/58 , 19____, to 4/22/58 , 19____, that I last saw the deceased alive on 4/22/58 , 19____, and that death occurred at 9:45 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>[Signature]</i>				ADDRESS (Street, city or town, state) Cumberland, Md.			
DATE SIGNED 4/25/58							
PHYSICIAN'S NAME (Type) DR. RICHARD J. WILLIAMS							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-25-58		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				24a. REC'D BY REGISTRAR DATE APR 25 '58		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

BUREAU V. S.

APR 25 1963

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4074

CERTIFICATE OF DEATH

Reg. Dist. No.

04079

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 10 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Braddock Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mrs. Cora Elizabeth Terry		4. DATE OF DEATH Month Day Year April 20 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 11, 1879
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Lemhi, Idaho		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Zephania Yeariam		14. MOTHER'S MAIDEN NAME Sara Jane Yeariam	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Dr. R. Rhett Rathbone, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Mediastinal Metastasis DUE TO (c) Bronchogenic Carcinoma Left Lung		INTERVAL BETWEEN ONSET AND DEATH 10 days 4 month 10 Months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 11, 1957 to April 20, 1958 , that I last saw the deceased alive on April 20, 1958 , and that death occurred at 1 p. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 122 S. Centre St., Cumberland, Md.			
ACTUAL SIGNATURE R. Rhett Rathbone		M.D. April 20, 1958	
PHYSICIAN'S NAME (Type) Dr. R. Rhett Rathbone			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-23-58	22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	22d. LOCATION (City, town, or county) (State) Miami, Fla.
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		24a. REC'D BY REGISTRAR DATE APR 22 '58	
		24b. REGISTRAR'S SIGNATURE <i>W. H. Smith</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
ALFRED		19		MALE		WHITE		1938		BALTIMORE, MD	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF BIRTH		PLACE OF BIRTH	
BALTIMORE, MD		LABORER		HEART DISEASE		NATURAL		1919		BALTIMORE, MD	
FATHER		MOTHER		SPOUSE		CHILDREN		EDUCATION		RELIGION	
JOHN		MARY		JANE		JOHN		HIGH SCHOOL		CATHOLIC	
DATE OF INTERVIEW		INTERVIEWER		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		DATE OF BURIAL		PLACE OF BURIAL	
1938		J. H. SMITH						1938		BALTIMORE, MD	

RECEIVED
APR 22 1938
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

475

CERTIFICATE OF DEATH

Reg. Dist. No. 04080

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		d. STREET ADDRESS 802 Gephart Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle J. Last Tipton		4. DATE OF DEATH Month April Day 7 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/8/1871
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Teacher		10b. KIND OF BUSINESS OR INDUSTRY School Teacher	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Noah Tipton		14. MOTHER'S MAIDEN NAME Lavina Cook	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 335-16-7763	
17. INFORMANT P.O.Box 599 Allegany County Infirmary Records		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertension, Ch. Smiles DUE TO 260x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, Smiles DUE TO Diabetes Mellitus (c) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/17/58 , 19____, to 4/7/58 , 19____, that I last saw the deceased alive on 4/7/58 , 19____, and that death occurred at 7:50A M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 49 Greene Street DATE SIGNED 4/7/58	
ACTUAL SIGNATURE R. Macalester, M.D.		M.D. 49 Greene Street	
PHYSICIAN'S NAME (Type) Dr. Lee B. Mathews		Cumberland, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/9/58	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Mausoleum		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR APR 11 '58		24b. REGISTRAR'S SIGNATURE W. H. Couch	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4076 CERTIFICATE OF DEATH

04081

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS 924 GLENWOOD STREET	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EVA Middle M. Last TROUT		4. DATE OF DEATH Month APRIL Day 9 Year 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 1904 OCTOBER 1904
9. AGE (In years last birthday) 53		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) MARYLAND, Westernport		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN WILLIAMS		14. MOTHER'S MAIDEN NAME LOTTIE STEINE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-36-7713	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General metastatic Carcinoma originating DUE TO (b) in female organs DUE TO (c) 176.9 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1956 , to April 9 , 19 58 , that I last saw the deceased alive on April 8 , 19 58 , and that death occurred at 5:00 A. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Carlton Brinsfield		ADDRESS (Street, city or town, state) 232 Baltimore Ave DATE SIGNED April 19, 1958	
PHYSICIAN'S NAME (Type) DR. C. BRINSFIELD		Cumberland Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 11, 1958	
22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR APR 14 '58 24b. REGISTRAR'S SIGNATURE W. J. ...	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

BUREAU V. 3.

APR 14 1950

RECEIVED

- MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04082

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

4994

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 40 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. at-Miners Hospital			d. STREET ADDRESS 156 Mc Culloh St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Richard Middle Truly Last Truly			4. DATE OF DEATH Month April Day 28 Year 19 58		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8-1882	9. AGE (in years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired-Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Lonaconing, Md,	
13. FATHER'S NAME William Truly		14. MOTHER'S MAIDEN NAME Margaret Graham			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 2I4-I6-2032		17. INFORMANT Address (son) Lloyd Truly, Frostburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary sclerosis (a), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH sudden about 2 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Frostburg	(County) Allegany	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE H.V. Deming M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED April 29-1958	
EXAMINER'S NAME (Type) H.V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-I-1958	22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Pk, Frostburg		22d. LOCATION (City, town, or county) (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles H. Mattingley		ADDRESS Hafer Funeral Home Frostburg, Md.		24a. REC'D BY REGISTRAR DATE MAY 5 '58	24b. REGISTRAR'S SIGNATURE W. H. Smith

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by 1/2 funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove Corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4077

CERTIFICATE OF DEATH

Reg. Dist. No.

04083

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hosp.		d. STREET ADDRESS 34 Greene St.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ARIZONA Middle ETHEL Last VANDERGRIFT		4. DATE OF DEATH Month April Day 16 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 18, 1884
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Monongalia Co. W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Oregon Vandergrift		14. MOTHER'S MAIDEN NAME Louernia Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No,		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Flora G. Robinette		Address 32 Greene St., Cumb.Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Stomach 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Abdominal carcinomatosis DUE TO (c) none		INTERVAL BETWEEN ONSET AND DEATH 2 mo. 1 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. none 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 22, 1958 , to April 16, 1958 , that I last saw the deceased alive on April 16, 1958 , and that death occurred at 2:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James P. Hallinan M.D.		ADDRESS (Street, city or town, state) 140 Bedford St.,	
DATE SIGNED APR 18 1958			
PHYSICIAN'S NAME (Type) James P. Hallinan M. D.		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/19/58	
22c. NAME OF CEMETERY OR CREMATORY Shinnston Masonic Cemetery		22d. LOCATION (City, town, or county) (State) Shinnston, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR APR 18 1958		24b. REGISTRAR'S SIGNATURE Arthur Beach	

CERTIFICATE OF DEATH

BUREAU V. S.

APR 18 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04084

4-95

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				d. STREET ADDRESS Railroad Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Douglas Middle G. Last Waddell				4. DATE OF DEATH Month April Day 28 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 21, 1871		9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mine		11. BIRTHPLACE (State or foreign country) Lonaconing, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Waddell				14. MOTHER'S MAIDEN NAME Jessie Graham			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 214-32-3177		17. INFORMANT Address Mrs. Douglas Waddell Lonaconing, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO (b) Benign Prostatic Hypertrophy DUE TO (c) Cerebral Vascular Accident - Arteriosclerosis CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH 10 days years 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 1, 1957 to April 28, 1958 , that I last saw the deceased alive on April 27, 1958 , and that death occurred at 2:00 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) MAIN ST LONA CONING MD. DATE SIGNED 4.29.58							
ACTUAL SIGNATURE Leslie R. Miles Jr.		M.D. MAIN ST					
PHYSICIAN'S NAME (Type) LESLIE R. MILES JR.		LONA CONING MD.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/30/58		22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		22d. LOCATION (City, town, or county) (State) Lonaconing, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn				ADDRESS Lonaconing, Md.		24a. REC'D BY REGISTRAR DATE 5 58	
				24b. REGISTRAR'S SIGNATURE W. J. Smith			

CERTIFICATE OF DEATH

NAME OF DECEASED George Richmond		SEX Male		AGE 30	
DATE OF DEATH April 10, 1930		PLACE OF DEATH Home		CITY OF DEATH Birmingham	
CAUSE OF DEATH Pneumonia		MANNER OF DEATH Natural		PLACE OF BURIAL Home	
DATE OF BURIAL April 10, 1930		PLACE OF BURIAL Home		CITY OF BURIAL Birmingham	
NAME OF DECEASED George Richmond		SEX Male		AGE 30	
DATE OF DEATH April 10, 1930		PLACE OF DEATH Home		CITY OF DEATH Birmingham	
CAUSE OF DEATH Pneumonia		MANNER OF DEATH Natural		PLACE OF BURIAL Home	
DATE OF BURIAL April 10, 1930		PLACE OF BURIAL Home		CITY OF BURIAL Birmingham	
NAME OF DECEASED George Richmond		SEX Male		AGE 30	
DATE OF DEATH April 10, 1930		PLACE OF DEATH Home		CITY OF DEATH Birmingham	
CAUSE OF DEATH Pneumonia		MANNER OF DEATH Natural		PLACE OF BURIAL Home	
DATE OF BURIAL April 10, 1930		PLACE OF BURIAL Home		CITY OF BURIAL Birmingham	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4078

CERTIFICATE OF DEATH

Reg. Dist. No. 04085

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 6/8/57	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Mamie Last Washington		4. DATE OF DEATH Month April Day 9 Year 1958	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/14/1890
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months 6 Days 14 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Housework		10b. KIND OF BUSINESS OR INDUSTRY Oldtown, Maryland	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT P.O.Box 599 Allegany County Infirmary Records		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis, Chronic degenerative 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic arteriosclerosis, DUE TO (c) Coarctation; Residuals of 4 times Burns		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/8/57 , 19____, to 4/9/58 , 19____, that I last saw the deceased alive on 4/9/58 , 19____, and that death occurred at 8:35 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene Street DATE SIGNED 4/9/58 ACTUAL SIGNATURE Dr. Lee B. Mathews M.D. Cumberland, Maryland PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 11, 1958	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR DATE APR 14 '58	
24b. REGISTRAR'S SIGNATURE Allegany			

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar	
John Doe		45		Male		White		1910		1955		Home		Heart Disease		Natural		J. Doe, M.D.		J. Doe, M.D.	
Occupation		Education		Marital Status		Previous Illnesses		Date of Last Examination		Date of Last Examination		Date of Last Examination		Date of Last Examination		Date of Last Examination		Date of Last Examination		Date of Last Examination	
Farmer		High School		Married		None		1954		1954		1954		1954		1954		1954		1954	
Date of Death		Time of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death		Place of Death		Cause of Death	
1955		10:00 AM		Home		Heart Disease		Natural		J. Doe, M.D.		J. Doe, M.D.		1955		10:00 AM		Home		Heart Disease	

BUREAU V. S.
APR 14 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 9, Film G228, 4/21/58 fcy

CERTIFICATE OF DEATH

Reg. Dist. No. 04086

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
c. LENGTH OF STAY IN 1b 5 days				d. STREET ADDRESS 722 ELM STREET			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FLORENCE Middle W. Last WEIRES				4. DATE OF DEATH Month APRIL Day 7 Year 19 58			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 21, 1898	
9. AGE (In years lost birthday) 60 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY Grocery Store		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA -Myersdale USA	
13. FATHER'S NAME JOHN BAKER				14. MOTHER'S MAIDEN NAME REBECCA FLOTO			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 218-24-8086			
				17. INFORMANT PATIENT'S NIECE Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis DUE TO Hypertensive C-V Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac Hypertrophy DUE TO (c) 3 yrs.							INTERVAL BETWEEN ONSET AND DEATH ant
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Apr. 2, 1958 to Apr. 7, 1958 that I last saw the deceased alive on Apr. 7, 1958 , and that death occurred at 2:10 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 4/8/58							
ACTUAL SIGNATURE James F. Scarpelli M.D.							
PHYSICIAN'S NAME (Type) James F. Scarpelli							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-10-58		22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md. ADDRESS				24a. REC'D BY REGISTRAR APR 10 '58		24b. REGISTRAR'S SIGNATURE Alfred Smith	

CERTIFICATE OF DEATH

4030

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		APR 10 1958	
AGE		SEX	
65		M	
RACE		OCCUPATION	
W		RETIRED	
PLACE OF BIRTH		CITY OF RESIDENCE	
BALTIMORE, MD		BALTIMORE, MD	
DATE OF BIRTH		PLACE OF BIRTH	
APR 10 1893		BALTIMORE, MD	
CAUSE OF DEATH		MANNER OF DEATH	
CORONARY THROMBOSIS		NATURAL	
IMMEDIATE CAUSE		UNDERLYING CAUSE	
HEART FAILURE		CORONARY THROMBOSIS	
DATE OF EXAMINATION		PLACE OF EXAMINATION	
APR 10 1958		BALTIMORE, MD	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
JAMES H. HARRIS		JAMES H. HARRIS	
DATE OF SIGNATURE		DATE OF SIGNATURE	
APR 10 1958		APR 10 1958	

BUREAU V. 1

APR 10 1958

RECEIVED

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH AND IS NOT VALID FOR THE PURPOSES OF THE FEDERAL GOVERNMENT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04087

4980

Reg. Dist. No.

FOR STATE
HEALTH DEPT.1. PLACE OF DEATH
a. COUNTY

Allegheny

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Md

b. COUNTY

Allegheny

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

c. LENGTH OF STAY IN 1b

84 yrs

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

02 Cumberland

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Sacred Heart Hospital

d. STREET ADDRESS

1626 Bedford St

e. IS RESIDENCE
ON A FARM?YES ☐ NO ☒3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

Amelia

Christina

White

4. DATE
OF
DEATH

Month

Day

Year

April

7

19

58

5. SEX

female

6. COLOR OR RACE

white

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

June 26-1873

9. AGE (In years
last birthday)

84 yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George Leibrant

14. MOTHER'S MAIDEN NAME

Elizabeth Reub

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(If yes, no, or unknown)

no

16. SOCIAL SECURITY NO.

none

17. INFORMANT

Address

daughter Mrs. Henry Lee, Cumberland, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Myocardial failure

INTERVAL BETWEEN
ONSET AND DEATH

gradual

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

Chronic myocarditis

DUE TO

(c)

?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY
PERFORMED?YES ☐ NO ☒20a. EXTERNAL CAUSE WAS
PRIMARY ☐ or CONTRIBUTING ☐
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Month, Day, Year
Hour a. m.
p. m.

19

20d. INJURY OCCURRED
While of work ☐ Not while
of work ☐20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐. Inspection ☒. Inquiry ☒. and in my opinion death resulted from: Natural causes ☒. Accident ☐. Suicide ☐. Homicide ☐. Undetermined manner ☐ACTUAL
SIGNATURE

H.V. Deming M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ASSISTANT MEDICAL EXAMINER ☐EXAMINER'S
NAME (Type)

H.V. Deming M.D.

DEPUTY MEDICAL EXAMINER ☒ April 7-195822a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

Apr. 9, 1958

22c. NAME OF CEMETERY OR CREMATORY

St. Lukes Luth. Cemetery

22d. LOCATION (City, town, or county)

Cumberland, Maryland

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

John J. Hafer, Cumberland, Maryland

24a. REC'D BY REGISTRAR

DATE APR 10 '58

24b. REGISTRAR'S SIGNATURE

Allan Leach

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

DATE OF DEATH

PLACE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF CREMATION

PLACE OF CREMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

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DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

BUREAU V. 2

APR 10 1953

RECEIVED

CERTIFICATE OF DEATH

04088

Reg. Dist. No.

4105

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		MARYLAND		STATE Md.		COUNTY Allegany	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Luke				TOWN Luke			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
Residence				430 Pratt St.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) George (Middle) Oliver (Last) Williams				(Month) April (Day) 15 (Year) 19 58			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White	Widowed	Jan 5 1893	65 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Papermaker		W.Va. P & P co.		Piedmont, W.Va		U.S	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
O.D. Williams				Leota Rector			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
no		216-05-9744		Oliver Williams, Luke, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
1410 IMMEDIATE CAUSE (A)				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO				Generalize Carcinoma			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO				18mo.			
(C)				Carcinoma Base of Tongue			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 1, 1957 , to Apr 5, 1958 , that I last saw the deceased alive on Apr 5, 1958 , and that death occurred at 4 P.M. from the causes and on the date stated above.							
SIGNATURE J. E. Berry				ADDRESS (Street, city, town, state) Piedmont W.Va			
M.D. Piedmont W.Va				DATE SIGNED 4/7/58			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
Burial		April 2. 58		Philos Cemetery		Westernport, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE APR 8 '58		Alfred Smith		W. H. Finkbeiner Jr.		Piedmont, W.Va.	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
George Williams		Male		35		Jan 1, 1901		Boston, Mass.	
6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF DEATH		10. DATE OF DEATH	
Clerk		Heart Disease		Natural		Home		Jan 15, 1938	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF WITNESSES		14. SIGNATURE OF DECEASED		15. SIGNATURE OF NEXT OF KIN	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

RECEIVED
APR 8 1938
BUREAU V. 2

MASSACHUSETTS
DEPARTMENT OF HEALTH
BOSTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4981 CERTIFICATE OF DEATH

Reg. Dist. No. 04089

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Daisy Middle W. Last Wilson		4. DATE OF DEATH Month April Day 3 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/13/1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Seamstress - Rosenbaum's		11. BIRTHPLACE (State or foreign country) Rawlings, Maryland	
13. FATHER'S NAME John F. Wilson		14. MOTHER'S MAIDEN NAME Esther Chaney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service) 214-05-8351		17. INFORMANT P.O.Box 599 Address Cumberland, Md. Allegany County Infirmary Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary sclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis DUE TO (c) Cerebral arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 22 hrs ? ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Nephritis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6/7/54 , 19____, to 4/3/58 , 19____, that I last saw the deceased alive on 4/3/58 , 19____, and that death occurred at 4:05 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene Street DATE SIGNED 4/4/58			
ACTUAL SIGNATURE James E. McLean M.D.		DATE SIGNED 4/4/58	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		Cumberland, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 7/7/58	22c. NAME OF CEMETERY OR CREMATORY Greenmount Cem.	22d. LOCATION (City, town, or county) (State) Cumb. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc. ADDRESS Cumb. Md.		24a. REC'D BY REGISTRAR APR 7 '58	24b. REGISTRAR'S SIGNATURE W. H. Beach

CERTIFICATE OF DEATH

NAME OF DECEASED Gumbertland, Maryland		AGE 67.5		SEX Male		RACE White	
DATE OF DEATH 10/12/1958		PLACE OF DEATH Home		CITY Baltimore		STATE Maryland	
CAUSE OF DEATH Ischemic heart disease		MANNER OF DEATH Natural		OCCUPATION Retired		EDUCATION High School	
DATE OF BIRTH 10/12/1958		PLACE OF BIRTH Maryland		CITY Baltimore		STATE Maryland	
FATHER'S NAME John A. Gumbertland		MOTHER'S NAME Mary A. Gumbertland		FATHER'S OCCUPATION Retired		MOTHER'S OCCUPATION Homemaker	
FATHER'S ADDRESS 1015 N. E. St.		MOTHER'S ADDRESS 1015 N. E. St.		FATHER'S PHONE 7-1234		MOTHER'S PHONE 7-1234	
FATHER'S SIGNATURE John A. Gumbertland		MOTHER'S SIGNATURE Mary A. Gumbertland		DECEASED'S SIGNATURE Maryland Gumbertland		WITNESS'S SIGNATURE Maryland Gumbertland	
FATHER'S ADDRESS 1015 N. E. St.		MOTHER'S ADDRESS 1015 N. E. St.		DECEASED'S ADDRESS 1015 N. E. St.		WITNESS'S ADDRESS 1015 N. E. St.	
FATHER'S PHONE 7-1234		MOTHER'S PHONE 7-1234		DECEASED'S PHONE 7-1234		WITNESS'S PHONE 7-1234	
FATHER'S SIGNATURE John A. Gumbertland		MOTHER'S SIGNATURE Mary A. Gumbertland		DECEASED'S SIGNATURE Maryland Gumbertland		WITNESS'S SIGNATURE Maryland Gumbertland	
FATHER'S ADDRESS 1015 N. E. St.		MOTHER'S ADDRESS 1015 N. E. St.		DECEASED'S ADDRESS 1015 N. E. St.		WITNESS'S ADDRESS 1015 N. E. St.	
FATHER'S PHONE 7-1234		MOTHER'S PHONE 7-1234		DECEASED'S PHONE 7-1234		WITNESS'S PHONE 7-1234	
FATHER'S SIGNATURE John A. Gumbertland		MOTHER'S SIGNATURE Mary A. Gumbertland		DECEASED'S SIGNATURE Maryland Gumbertland		WITNESS'S SIGNATURE Maryland Gumbertland	

BUREAU V. S.

APR 7 1958

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6/1/58

Dr. James E. Gumbertland

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

496

CERTIFICATE OF DEATH

Reg. Dist. No. 04090

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>ALLEGANY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FROSTBURG, MD</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BARTON, MD</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MINORS Hosp Frostburg, MD</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LUVERNA</u> <u>WILT</u>				4. DATE OF DEATH Month Day Year <u>APRIL 10 1958</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 20 1880</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>GARRETT Co., MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JACOB BITTINGER</u>				14. MOTHER'S MAIDEN NAME <u>ELLA FAZENBAKER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>Miss Alois Moore, Barton MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute left heart failure, myocarditis</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>260X</u> (b) <u>Atherosclerosis</u> DUE TO (c) <u>years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Mar 31, 1958</u> , to <u>April 10, 1958</u> , that I last saw the deceased alive on <u>April 10, 1958</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Leslie R. Miles Jr.</u> M.D. <u>MAIN ST.</u>				DATE SIGNED <u>4-11-58</u>			
PHYSICIAN'S NAME (Type) <u>LESLIE R. MILES SR</u> <u>LONA CONING</u> <u>MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/13/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BITTINGER</u>		22d. LOCATION (City, town, or county) (State) <u>BITTINGER GARRETT Co., MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Don Newman, Grantville, MD</u>				24a. REC'D BY REGISTRAR DATE <u>APR 16 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Quilman</u>	

BUREAU V

APR 16 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4982

Reg. Dist. No. 44091

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Charles Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 57 Yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 420 Grand Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles Edgar Zimmerman		4. DATE OF DEATH April 7 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 16-1900
9. AGE (in years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		12. KIND OF BUSINESS OR INDUSTRY B&O.R.Ry.	
13. BIRTHPLACE (State or foreign country) Cumberland, Md.		14. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. FATHER'S NAME John E. Zimmerman		16. MOTHER'S MAIDEN NAME Mildred Racey	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		18. SOCIAL SECURITY NO. 705-05-4835	
19. INFORMANT (son) Charles Zimmerman, Old Town, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH sudden ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE H.V. Deming M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H.V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED April 7-1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-10-1958	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		24a. REC'D BY REGISTRAR DATE APR 10 '58	
24b. REGISTRAR'S SIGNATURE W. L. Leach			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MISSISSIPPI
DEPARTMENT OF HEALTH



MISSISSIPPI STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE	
JAMES H. HARRIS		Male		45	
RESIDENCE		OCCUPATION		CAUSE OF DEATH	
123 Main St., Jackson, Miss.		Farmer		Heart Disease	
DATE OF DEATH		PLACE OF DEATH		MANNER OF DEATH	
April 10, 1933		Home		Natural	
TIME OF DEATH		TEMPERATURE		PULSE	
10:00 AM		98.6 F		60	
SIGNATURE OF EXAMINER		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED	
J. H. Harris		J. H. Harris		J. H. Harris	
DATE OF EXAMINATION		DATE OF EXAMINATION		DATE OF EXAMINATION	
April 10, 1933		April 10, 1933		April 10, 1933	

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APR 10 1933

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